## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

**PAGE(S) 32** 

#### **CLAIMS FILING**

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

### CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

### **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:

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

Services may be billed using:

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

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid 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.

## **PAGE(S) 32**

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

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS. NOTE: The recipients' 13-digit Medicaid ID number <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 NUCC USE	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 be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9с	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
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	<ul> <li>Situational – Complete if applicable.</li> <li>In the following circumstances, entering the name of the appropriate physician block is required:</li> <li>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.</li> </ul>	
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.	

### 07/19/17 09/28/15

## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

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. 9 ICD-9-CM 0 ICD-10-CM Required – Enter the most current ICD diagnosis code. NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid	The most specific diagnosis codes must be used. General codes are not acceptable. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service 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	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.         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	Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12). 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 <b>required</b> 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>shall be</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	<b>Required</b> Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	Required Enter the appropriate place of service code for the services rendered.	

## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

Locator #	Description	Instructions	Alerts
24C	EMG	Situational – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	<ul> <li>Required Enter the procedure code(s) for services rendered.</li> <li>Enter the appropriate encounter procedure code on the first line.</li> <li>Encounter Codes: <ul> <li>RHC encounter visit: T1015</li> <li>RHC obstetrical service: T1015 w/TH modifier.</li> <li>RHC EPSDT service: T1015 w/EP modifier.</li> </ul> </li> <li>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.</li> </ul>	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	Amount Charged	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	I.D. Qual.	Optional.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	
25	Federal Tax I.D. Number	Optional.	

# PAGE(S) 32

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	<b>Situational</b> – 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?	<b>Optional</b> . Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	<ul> <li>Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor.</li> <li>Enter '0' if the third party did not pay.</li> <li>If TPL does not apply to the claim, leave blank.</li> </ul>	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	<b>Optional</b> . – 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	Unlabeled	Optional.	
33	Billing Provider Info & Phone #	<b>Required</b> Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional	
33b	Unlabeled	<ul> <li>Required – Enter the billing provider's 7-digit Medicaid ID number.</li> <li>ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.</li> </ul>	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

### Sample forms on the following pages

## PAGE(S) 32

## Sample of RHC CMS-1500 Claim Form with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

EALTH INSURANCE CLAIM	ORM							
PROVED BY NATIONAL UNIFORM CLAIM COM								
PICA								PICA
. MEDICARE MEDICAID TRICARE (Medicare #) X (Medicaid #) (ID#DoD	CHAMPV (Member	HEALTH PL	FECA LAN BLK LUN (ID#)	G OTHER (ID#)	1a. INSURED'S I.D 1234567890		(	For Program in Item 1)
PATIENT'S NAME (Last Name, First Name, Mid		3. PATIENT'S BIR MM DD		SEX			me, First Name, Mid	dle Initial)
.OU, JANNIE		06 19	85 M	FΧ			and the second se	
PATIENT'S ADDRESS (No., Street)		6. PATIENT RELA Self Spour	TIONSHIP TO INS	URED Other	7. INSURED'S ADI	JRESS (NO.,	Street)	
ſΥ	STATE	8. RESERVED FOR	R NUCC USE		СПҮ			STATE
P CODE TELEPHONE (In	lude Area Code)	-			ZIP CODE		TELEPHONE (In	dude Area Code)
( )							( )	
OTHER INSURED'S NAME (Last Name, First Na	me, Middle Initial)	10. IS PATIENT'S	CONDITION REL	ATED TO:	11. INSURED'S PO	LICY GROU	IP OR FECA NUMB	ER
OTHER INSURED'S POLICY OR GROUP NUM	ER	a. EMPLOYMENT	? (Current or Previo	ous)	a. INSURED'S D MM D		тн	SEX
PL Code if applicable RESERVED FOR NUCC USE		-	YES NO				M	F
NEOLAYED FOR HOUGO USE		b. AUTO ACCIDE		PLACE (State)	b. OTHER CLAIM I	u (Designate	a by NUCC)	
RESERVED FOR NUCC USE				<b>C</b>	c. INSURANCE PL	AN NAME O	R PROGRAM NAM	E
INSURANCE PLAN NAME OR PROGRAM NAM	-	104 RESERVED	YES NO				TH BENEFIT PLAN	)
	FΧΔ	MРI	FO	F I <i>C</i>				
READ BACK OF FORM PATIENT'S OR AUTHORIZED PERSON'S SIG	ATURE I authorize the	& SIGNING THIS F	ORM. ical or other informa	ation necessary	13. INSURED S OF payment of med	AUTHORIZ	ED PERSON'S SIG	ns 9 9a and 9d NATURE I authorize physician or supplier for
to process this claim. I also request payment of go below.	vernment benefits either	to myself or to the pa	rty who accepts ass	ignment	services descrit	ed below.	Ŭ	
SIGNED		DATE			SIGNED			
DATE OF CURRENT ILLNESS, INJURY, or PR		DTHER DATE	MM DD	YY	16. DATES PATIEN	DD YY	TO WORK IN CURP MI TO	
QUAL. NAME OF REFERRING PROVIDER OR OTHE	QU SOURCE 17a		i			UN DATES	RELATED TO CUR	RENT SERVICES
	71b	. NPI			FROM		то	
ADDITIONAL CLAIM INFORMATION (Design at	d by NUCC)				20. OUTSIDE LAB	1	\$ CHARGE	IS
DIAGNOSIS OR NATURE OF ILLNESS OR INJ	JRY Relate A-L to se	ervice line below (248	E) ICD Ind 9		YES 22. RESUBMISSIO CODE	NO N	ORIGINAL REF.	NO.
V2501 B.	C. [		D.					
F	G. [		н 📃		23. PRIOR AUTHO	RIZATION N	IUMBER	
A. DATE(S) OF SERVICE B. From To Place	C. D.PROC	EDURES, SERVICE	S, OR SUPPLIES	E. DIAGNOSIS	F.	G. DAYS	H. I. EPSOT ID.	J. RENDERING
M DD YY MM DD YY SERV	EMG CPT/HO	PCS M	ODIFIER	POINTER	\$ CHARGES	UNITS	Plan QUAL.	PROVIDER ID. #
3 02 14 03 02 14 11	T101	5		A	150 00	0 1		236548 236549875
		- 1 1		1				236548
3 02 14 03 02 14 11 00703680101 UN150.00 DEPO	9921 ROVERA INJ	3		A	00	0 1		236549875 236548
3 02 14 03 02 14 11		0		А	00	150		236549875
	1 1						NPI	
		<u> </u>	<u>i i</u>	1	<u> </u>		1 1 0051	
							NPI	
	1 1						NPI	
. FEDERAL TAX I.D. NUMBER SSN EI	26. PATIENT'S	ACCOUNT NO.	27. ACCEPT AS (For govt. claims X YES	SIGNMENT? , see back) NO	28. TOTAL CHAR \$ 15		9. AMOUNT PAID	30. BALANCE DUE
SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE F	ACILITY LOCATION			\$ 10 33. BILLING PRO		*	\$ ) 555-4957
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					Always Ope 123 Main St		QHC	,
Jana Dao MD	11				Any Town, L			24567
GNED Jane Doe, MD DATE 3/9	14 a.	b.			a. 1326547	092	ь. 12	34567

## **PAGE(S) 32**

## Sample of RHC CMS-1500 Claim Form with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

EALTH INSURAN			JCC) 02/12									
PICA												PICA
MEDICARE MEDICAII (Medicare #) X (Medicaid)			CHAMPVA (Member ID#,	GROUP HEALTH PLAI ((D#)	FECA N BLKLU (/D#)	ING (IDW)	1a. INSURED'S I 123456789		t		ForProgra	m in Item 1)
PATIENT'S NAME (Last Nam		<u> </u>	3	PATIENTS BIRTH		SEX	4. INSURED'S N		ame, First	t Name, Mid	die Initial)	
OU, JANNIE	0			06 19	85 M	F X	7. INSURED'S A		Cim of			
PATIENT'S ADDRESS (No., :	street)		6	. PATIENT RELATI Self Spouse	Child	Other	7. INSURED'S A	DDRE55 (NO	x, street)			
ΠY			STATE 8.	RESERVED FOR M	NUCC USE		CITY					STATE
IP CODE	TELEPHONE (In	dude Area (	Code)				ZIP CODE		TELE	EPHONE (In	clude Area	Code)
	( )								(	( )		
OTHER INSURED'S NAME (	Last Name, First Na	ame, Middle I	Initial) 1	0. IS PATIENT'S C	ONDITION RE	LATED TO:	11. INSURED'S F	POLICY GRO	UP OR F	ECA NUMB	ER	
OTHER INSURED'S POLICY	OR GROUP NUME	BER	a	EMPLOYMENT? (	Current or Pre	vious)	a. INSURED'S	DATE OF B	RTH		SEX	
PL Code if applicab				YE		10				м		F
RESERVED FOR NUCCUS	E		b			PLACE (State)	b. OTHER CLAIN	ID (Designa	ated by NU	UCC)		
RESERVED FOR NUCC USE			c		VIF	'LĽ	c. INSURANCE F	PLAN NAME	OR PROC	GRAM NAM	E	
				YE	S N	10						
INSURANCE PLAN NAME O	R PROGRAM NAM	E	1	0d. RESERVED FO	R LOCAL USE		d. IS THERE AN	OTHER HEA				
	BACK OF FORM		1PJ	VNIG IHISI D		<del>JF</del> -I			ED PER	xomplete iter RSON'S SIG	NATUREI	authorize
PATIENT'S OR AUTHORIZE to process this claim. I also re below.	D PERSON'S SIGN quest payment of go	vernment be	aumorize the re an efits eithert or	ieuse of ally medica nyselfor to the party	who accepts a	ssignment	services desc	redicar bene- atbed below.	to the u	indersigned	physician o	r supplier for
SIGNED				DATE			SIGNED					
DATE OF CURRENT ILLNE	SS, INJURY, or PRE	EGNANCY (	IND IS OT									
			(LMP) 10.011	IER DATE N	IM , DD ,	YY	16. DATES PATI MM	ENT UNABL	E TO WOR	M	RENT OCC	UPATION
	QUAL		QUAL	IER DATE N	IM DD	ΥY	FROM		~	то		YY
	QUAL		QUAL 17a		IM DD	YY	MM		~	то		ΥY
NAME OF REFERRING PR	QUAL OVIDER OR OTHER	R SOURCE	QUAL 17a. 71b. N		IM DD	YY	FROM 18. HOSPITALIZ/ MM		~	TO M	RENT SER	ΥY
NAME OF REFERRING PR	QUAL DVIDER OR OTHEI MATION (Designation	R SOURCE	QUAL 17a 71b. N				FROM 18. HOSPITALIZ/ MM FROM 20. OUTSIDE LA YES			TO ED TO CUR TO \$ CHARGE		ΥY
NAME OF RÉFERRING PR ADDITIONAL CLAIM INFOR	QUAL DVIDER OR OTHEI MATION (Designation	R SOURCE	QUAL 17a 71b. N	IPI	IM DD III III III III III III III III II		FROM 18. HOSPITALIZ/ MM FROM 20. OUTSIDE LA			TO M ED TO CUR TO		ΥY
NAME OF REFERRING PR ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE O	QUAL DVIDER OR OTHEI MATION (Designation FILLINESS OR INJ	R SOURCE	QUAL 17a 71b. N C) ate A-L to service	IPI	ICD Ind. 0		FROM 18. HOSPITALIZ/ MM FROM 20. OUTSIDE LA YES			TO ED TO CUR TO \$ CHARGE BINAL REF.		ΥY
NAME OF REFERRING PR ADDITIONAL CLAIM INFOR DIAGNOSI'S OR NATURE O . 1230011	QUAL DVIDER OR OTHEI MATION (Designation FILLNESS OR INJ B F J	R SOURCE	QUAL 17a. 71b. N 2) ate A-L to servit C G K	PI	ICD Ind. 0		FROM 18. HOSPITALIZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH	DD   1 ATION DATE B7 NO ION HORIZATION		TO ED TO CUR TO \$ CHARGE BINAL REF.		ΥY
NAME OF REFERRING PR           ADDITIONAL CLAIM INFOR           DIAGNOSIS OR NATURE O           .	QUAL DVIDER OR OTHEI MATION (Designation FILLNESS OR INJ B F J	R SOURCE ed by NUCC URY Reli	QUAL 17a. 71b. N 2) ate A-L to servit C G K D.PROCED	PI	ICD Ind. 0 D. L H. L OR SUPPLIES		FROM 18. HOSPITALIZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE			TO ED TO CUR TO \$ CHARGE BINAL REF.	M DD PRENT SER DD I I I I I I I I I I I I I	ΥY
NAME OF REFERRING PR ADDITIONAL QLAIM INFOR DIAGNOSIS OR NATURE O 	DUAL DVIDER OR OTHEI MATION (Designation FILLNESS OR INJ B. F. F. D.	R SOURCE ed by NUCC URY Reli	QUAL 17a 71b N 2) ate A-L to servit C G K D.PROCEDI D.PROCEDI (Explain CPT/HCPCS	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	S E. DIAGNOSIS POINTER	FROM 18. HOSPITALIZ/ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES			TO ED TO CUR TO S CHARGE GINAL REF.	RENT SER RENT SER 1 23 REN PROV 236548	J. DERING DER ID. #
NAME OF REFERRING PR ADDITIONAL QLAIM INFOR DIAGNOSIS OR NATURE O 	DUAL DVIDER OR OTHEI MATION (Designation F ILLNESS OR INJ B. F. J. J. CE B. B. D PLOE B. B. D PLOE B. B. CE B. B. CE B. B. CE B. B. CE B.	R SOURCE ed by NUCC URY Reli	QUAL 17a. 71b. N 2) ate A-L to servit C. [ G. [ D.PROCEDX (Explain	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	3 E. DIAGNOSIS	FROM 18. HOSPITALIZA FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F.			TO ED TO CUR TO S CHARGE GINAL REF. R L L L D QUAL 12 NPI 12	RENT SER RENT SER SS NO.	J. DERING DER ID. #
NAME OF REFERING PR           ADDITIONAL CLAIM INFOR           DAGNOSIS OR NATURE O	DUAL           DVIDER OR OTHEI           MATION (Design at           FILNESS OR INJ           B.           F.           J.           CE           DD           Y           IO           10           15           10           15	R SOURCE ed by NUCC URY Reli	QUAL 17a. 71b. N 71b. N 71	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	S E. DIAGNOSIS POINTER	FROM 18. HOSPITALIZ/ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES			TO ED TO CUP TO S CHARGE BINAL REF. R L L D UAL NPI 12 NPI 12	RENT SET NO. RENT SET NO. REN PROV 236548 236549 23654	J. DERING DER ID. # 375
NAME OF REFERING PR           ADDITIONAL CLAIM INFOR           DIAGNOSIS OR NATURE O           123 00 11           L           ADD TIONAL CLAIM INFOR           A. DATE(S) OF SERVING           M DD           YY           M DD           10           10           10           10           10           10           10           10           10           10	DUAL           DVIDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           F.           J.           CE           DD           Y           SERVICE           10           15           11           150,000	R SOURCE ed by NUCC URY Rel CE EMG	QUAL 17a. 71b. N 71b. N 71	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	B E DIAGNOSIS POINTER A A	FROM MM 18. HOSPITALIZZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES 160			TO MI ED TO CUE TO S CHARGE SINAL REF. R I I I I I I I I I I I I I I I I I I	RENT SET NO. RENT SET NO. RENT SET NO. RENT SET RENT SET R	J. DERING DERING DER ID. # 375
NAME OF REFERING PR           ADDITIONAL CLAIM INFOR           DIAGNOSIS OR NATURE O           1           23 00 11           .	DUAL           DVIDER OR OTHEI           MATION (Design at           FILNESS OR INJ           B.           F.           J.           CE           DD           Y           IO           10           15           10           15	R SOURCE ed by NUCC URY Rel CE EMG	QUAL 17a. 71b. N 71b. N 71	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	3 E. DIAGNOSIS POINTER A	FROM MM 18. HOSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBINISS CODE 23. PRIOR AUTH F. \$ CHARGES 160			TO MI ED TO CUE TO S CHARGE SINAL REF. R I I I I I I I I I I I I I I I I I I	RENT SET NO. RENT SET NO. REN PROV 236548 236549 23654	J. DERING DERING DER ID. # 375
NAME OF REFERRING PR           ADDITIONAL CLAIM INFOR           DAGNOSIS OR NATURE O	DUAL           DVIDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           F.           J.           CE           DD           Y           SERVICE           10           15           11           150,000	R SOURCE ed by NUCC URY Rel CE EMG	QUAL 17a. 71b. N 71b. N 71	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	B E DIAGNOSIS POINTER A A	FROM MM 18. HOSPITALIZZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES 160			TO MI ED TO CUE TO S CHARGE SINAL REF. R I I I I I I I I I I I I I I I I I I	RENT SET NO. RENT SET NO. RENT SET NO. RENT SET RENT SET R	J. DERING DERING DER ID. # 375
NAME OF REFERING PR           ADDITIONAL CLAIM INFOR           DIAGNOSIS OR NATURE O           1           23 00 11           .	DUAL           DVIDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           F.           J.           CE           DD           Y           SERVICE           10           15           11           150,000	R SOURCE ed by NUCC URY Rel CE EMG	QUAL 17a. 71b. N 71b. N 71	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	B E DIAGNOSIS POINTER A A	FROM MM 18. HOSPITALIZZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES 160			TO MI ED TO CUR TO S CHARGE SINAL REF. R L L D UNAL NPI 12 NPI 12 NPI 12 NPI 12	RENT SET NO. RENT SET NO. RENT SET NO. RENT SET RENT SET R	J. DERING DERING DER ID. # 375
NAME OF REFERRING PR           ADDITIONAL CLAIM INFOR           DIAGNOSIS OR NATURE O	DUAL           DVIDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           F.           J.           CE           DD           Y           SERVICE           10           15           11           150,000	R SOURCE ed by NUCC URY Rel CE EMG	QUAL 17a. 71b. N 71b. N 71	PI	ICD Ind. 0 D. L H. L OR SUPPLIES ances)	B E DIAGNOSIS POINTER A A	FROM MM 18. HOSPITALIZZ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES 160			TO MI ED TO CUR TO S CHARGE JINAL REF. R L UNAL NPI 12 12 NPI 12 12 NPI 12	RENT SET NO. RENT SET NO. RENT SET NO. RENT SET RENT SET R	J DERING DERING DER ID. # 375
NAME OF REFERRING PR           ADDITIONAL CLAIM INFOR           DAGNOSIS OR NATURE O           Z3 00 11 <tr td=""></tr>	DUAL           DMATION (Design ab           MATION (Design ab           FILNESS OR INJ           B.           F.           J.           CE           D0           Y           B.           J.           D0           Y           SERM           10           15           11           J.	R SOURCE ed by NUCC URY Rel C. C C C C C O C O C C C C C C C C C C	QUAL 17a. 71b. N 71b. N 71	PPI		B DIAGNOSIS POINTER A A A	FROM MM 18. HOSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBMISS CODE 23. PRIOR AUTH F. \$ CHARGES 160 0			TO MI ED TO CUR TO S CHARGE SINAL REF. R L ID ID ID ID ID ID ID ID ID ID ID ID ID	REN 6549 236548 2365492 236	۷۲ ۱۵ ۱۵ ۱۵ ۱۵ ۱۵ ۱۵ ۱۵ ۱۵ ۱۵ ۱۵
NAME OF REFERRING PR           ADDITIONAL CLAIM INFOR           DAGNOSIS OR NATURE O           Z3 00 11 <tr td=""></tr>	DUAL           DMATION (Design ab           MATION (Design ab           FILNESS OR INJ           B.           F.           J.           CE           D0           Y           B.           J.           D0           Y           SERM           10           15           11           J.	R SOURCE ed by NUCC URY Ref  C. C. EMG O-ROVE	QUAL 17a 71b N 71b N	PPI		B E DIAGNOSIS POINTER A A	FROM MM 18. HOSPITALIZ/ FROM 20. OUTSIDE LA YES 22. RESUBMISS 23. PRIOR AUTH F. \$ CHARGES 160 0 0 0 28. TOTAL CHA			TO MI ED TO CUR TO S CHARGE SINAL REF. R L ID. QUAL NPI 12 NPI 12 NPI 12 NPI 12 NPI 12	REN 607 REN	۲۲ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰
AAME OF REFERRING PR     ADDITIONAL CLAIM INFOR     DAGNOSIS OR NATURE O     JZ3 00 11     E     L     AA DATE(S) OF SERVI     M DD YY MM     0 10 15 10     10 15 10     10 15 10     10 15 10     I	DUAL           DMDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           J.           B.           J.           J.           DO           Y           PLOCE           DO           TO           TO           10           15           10           15           10           15           10           15           R           SSN EIN           NOR SUPPLIER	R SOURCE edby NUCC URY Rei CC. CC. EMG O-ROVE	QUAL 17a 71b N 71b N	PPI		B DIAGNOSIS POINTER A A A SSIGNMENT? R:sebbbl)	FROM MM 18. HOSPITALIZ/ FROM 20. OUTSIDE LA YES 22. RESUBMISS 23. PRIOR AUTH F. \$ CHARGES 160 0 0 0 28. TOTAL CHA	DD         1           ATION DATE         1           B7         NO           KORIZATION         00           000         00           000         00           000         00           000         00           000         00           000         00           000         00           000         00           000         00           000         00	Y SRELATI ORIC NUMBEF S S S S S S S S S S S S S	TO MI ED TO CUR TO S CHARGE JINAL REF. R R IL ID OUAL II NPI II NPI II NPI II NPI II NPI II NPI II NPI II NPI II NPI II NPI II NPI II NPI	REN 6549 236548 2365492 236	J DERING DERING DERING DER ID. # 375 375 375 400 400 400 400 400 400 400 400 400 40
NAME OF REFERRING PR           ADDITIONAL CLAIM INFOR           DAGNOSIS OR NATURE O           DIAGNOSIS OR NATURE O           I	DUAL           DMDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           F.           J.           B.           J.           B.           J.           DD           Y           B.           J.           J.           DD           Y           B.           J.           J. </td <td>R SOURCE edby NUCC URY Rei CC. CC. EMG O-ROVE</td> <td>QUAL 17a 71b N 71b N</td> <td>PI IPI De line below (24E) JIRES, SERVICES, IUnusual Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL CROUMST IUNUSUAL CROUMST IUN</td> <td></td> <td>B DIAGNOSIS POINTER A A A SSIGNMENT? R:sebbbl)</td> <td>FROM MM 18. HOSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBNISS CODE 23. PRIOR AUTH 23. PRIOR AUTH 60 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td></td> <td>Y SRELATI ORIC NUMBEF S S S S S S S S S S S S S</td> <td>TO MI ED TO CUL TO S CHARGE SINAL REF. R L D D D D D D NPI 12 NPI 12 NPI</td> <td>PROV 236548 2365498 236548 2365498 2365498 236548 2365498 2365498 2365498 2365498 236548 2365498 2365498 2365498 236548 236548 2365498 236548 2365498 236548 236548 2365498 236548 246548 256548 25656666666666666666666</td> <td>۲۲ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰</td>	R SOURCE edby NUCC URY Rei CC. CC. EMG O-ROVE	QUAL 17a 71b N 71b N	PI IPI De line below (24E) JIRES, SERVICES, IUnusual Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL CROUMST IUNUSUAL CROUMST IUN		B DIAGNOSIS POINTER A A A SSIGNMENT? R:sebbbl)	FROM MM 18. HOSPITALIZJ FROM 20. OUTSIDE LA YES 22. RESUBNISS CODE 23. PRIOR AUTH 23. PRIOR AUTH 60 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Y SRELATI ORIC NUMBEF S S S S S S S S S S S S S	TO MI ED TO CUL TO S CHARGE SINAL REF. R L D D D D D D NPI 12 NPI	PROV 236548 2365498 236548 2365498 2365498 236548 2365498 2365498 2365498 2365498 236548 2365498 2365498 2365498 236548 236548 2365498 236548 2365498 236548 236548 2365498 236548 246548 256548 25656666666666666666666	۲۲ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰ ۱۰
NAME OF REFERRING PR     ADDITIONAL CLAIM INFOR     DAGNOSIS OR NATURE O     JZ3 00 11     JZ3 00 15     J0     J0 15 10     J0 15 10     J0 15 10     J0 15 10     J10 15     J10 1     J10 15     J10 1     J10 15     J10 1     J10 15     J10 1     J10 1	DUAL           DMDER OR OTHEI           MATION (Designation           MATION (Designation           FILINESS OR INJ           B.           F.           J.           B.           J.           B.           J.           DD           Y           B.           J.           J.           DD           Y           B.           J.           J. </td <td>R SOURCE edby NUCC URY Rei CC. CC. EMG O-ROVE</td> <td>QUAL 17a 71b N 71b N</td> <td>PI IPI De line below (24E) JIRES, SERVICES, IUnusual Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL CROUMST IUNUSUAL CROUMST IUN</td> <td></td> <td>B DIAGNOSIS POINTER A A A SSIGNMENT? R:sebbbl)</td> <td>FROM MM 18. HOSPITA.122 FROM 20. OUTSIDE LA YES 22. RESUBNISS 23. PRIOR AUTH 5. 160 0 0 28. TOTAL CHA 5 1 33. BILLUNG PR</td> <td>DD         1           ATTON DATE         1           B7         NO           KORIZATION         00           40RIZATION         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           000         00           000         00           000         00           000         00           000         00           000         000           000         000           000         000           000         000           000         000           000         000</td> <td>Y SRELATI ORIC NUMBEF B B B B C S S S S S S S S S S S S S</td> <td>TO MI ED TO CUL TO S CHARGE SINAL REF. R L D D D D D D NPI 12 NPI 12 NPI</td> <td>PROV 236548 2365498 236548 2365498 2365498 236548 2365498 2365498 2365498 2365498 236548 2365498 2365498 2365498 236548 236548 2365498 236548 2365498 236548 236548 2365498 236548 246548 256548 25656666666666666666666</td> <td>J DERING DERING DERING DER ID. # 375 375 375 400 400 400 400 400 400 400 400 400 40</td>	R SOURCE edby NUCC URY Rei CC. CC. EMG O-ROVE	QUAL 17a 71b N 71b N	PI IPI De line below (24E) JIRES, SERVICES, IUnusual Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL Croumst MOC IUNUSUAL CROUMST IUNUSUAL CROUMST IUN		B DIAGNOSIS POINTER A A A SSIGNMENT? R:sebbbl)	FROM MM 18. HOSPITA.122 FROM 20. OUTSIDE LA YES 22. RESUBNISS 23. PRIOR AUTH 5. 160 0 0 28. TOTAL CHA 5 1 33. BILLUNG PR	DD         1           ATTON DATE         1           B7         NO           KORIZATION         00           40RIZATION         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           00         00           000         00           000         00           000         00           000         00           000         00           000         000           000         000           000         000           000         000           000         000           000         000	Y SRELATI ORIC NUMBEF B B B B C S S S S S S S S S S S S S	TO MI ED TO CUL TO S CHARGE SINAL REF. R L D D D D D D NPI 12 NPI	PROV 236548 2365498 236548 2365498 2365498 236548 2365498 2365498 2365498 2365498 236548 2365498 2365498 2365498 236548 236548 2365498 236548 2365498 236548 236548 2365498 236548 246548 256548 25656666666666666666666	J DERING DERING DERING DER ID. # 375 375 375 400 400 400 400 400 400 400 400 400 40

# **PAGE(S) 32**

## Sample of a Claim Form

PICA					PICA
1. MEDICARE MEDICAID TRICARE CHAMPV	A GROUP HEALTH PLAN BLK LUNG (IDV) (IDV)	OTHER 1a. INSURED'S I.D.	NUMBER		(For Program in lasm 1)
(Medicare#) (Medicald#) (JD#/DoD#) (Member #			- 4 - 1 bloom		50.18 L M . 5
2. PATIENT'S NAME (Last Nams, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAM	e (clast marrie	, First Neime	a, whickes initially
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADD	RE88 (No., 9	irael)	
CITY STATE	8 RESERVED FOR NUCC USE	CITY		-	STATE
		70 2005			
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE		(	NE (Include Area Code)
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	: 11. INSURED'S POI	ICY GROUP	OR FECA N	UMBER
. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	A INSURED'S DAT	OF BIRTH		SEX
	YES NO	a. INSURED'S DATT	W.		F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENTY PLACE	(State) b. OTHER CLAIM ID	(Designated	by NUCC)	
a. RESERVED FOR NUCC USE	G. OTHER ACCIDENT?	a INSURANCE PLA		PROGRAM	NAME
	YES NO			BENCET	21 4510
AL INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOT	NO A	ryes, compl	lete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the r to process this claim. I also request payment of government benefits either the between the second sec	a SIGNING THIS FORM. release of any medical or other information nece	13. INSURED'S OR	AUTHORIZED	PERSON	S SIGNATURE I authoriza Igned physician or supplier for
to process this claim. I also request payment of government banefits either t below.	to myself or to the party who accepts assignmen	t services describe	ed below.		
SIGNED	DATE	SIGNED			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. 0	OTHER DATE MM DD YY	16. DATES PATIEN	UNABLE TO	WORK IN	CURRENT OCCUPATION
WOYLE		TTT.MI			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178.		18. HOSPITALIZATI	ON DATES R	ELATED TO	CURRENT SERVICES
176	NPI	FROM	ON DATES R	T	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	NPI	18. HOSPITALIZATI MM FROM 20. OUTSIDE LAB? YES		T	D CURRENT SERVICES MM DD YY D CHARGES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	NPI	FROM 20. OUTSIDE LAB?	NO	T	CHARGES
	INPI	FROM 20. OUTSIDE LAB? YES	NO	TR & ( ORIGINAL I	CHARGES
	NPI         ICD Ind.           bit         D.           H.         L	20. OUTSIDE LAB?		TR 8 ( ORIGINAL I MBER	O CHARGES
	INPI	20. OUTSIDE LAB?		ORIGINAL I MBER H. I.	O CHARGES
	INPI	E. FLOM		ORIGINAL I MBER H. I. Profit ID. Partity Cual	CHARGES
	INPI	20. OUTSIDE LAB?		ORIGINAL I MBER H. I.	O CHARGES
	INPI	20. OUTSIDE LAB?		ORIGINAL I MBER H. I. Profit ID. Partity Cual	O CHARGES
	INPI	20. OUTSIDE LAB?		ORIGINAL I ORIGINAL I MBER H, I, I PROTID NPI NPI NPI NPI	O CHARGES
	INPI	20. OUTSIDE LAB?		TI \$ 0 ORIGINAL I MBER H, I, I PROF ID. NPI NPI	O CHARGES
	INPI	20. OUTSIDE LAB?		ORIGINAL I ORIGINAL I MBER H, I, I PROTID NPI NPI NPI NPI	O CHARGES
	INPI	20. OUTSIDE LAB?		TI B ( ORIGINAL I MBER H, I, I PROV ID. I PROV NPI NPI NPI	O CHARGES
	INPI	20. OUTSIDE LAB?		TT BCC CORIGINAL I MBER H- Profy CUAL NPI NPI NPI NPI NPI NPI NPI NPI	O CHARGES
	NPI	PROM  20. OUTBIDE LAB? 20. OUTBIDE LAB? 22. FEBUGANISSION 23. PRIOR AUTHOR E. F. NOGIS F. NTER CHARGES		ORIGINAL I MBER Protor ID. Ferdy ID. Ferdy ID. NPI Marcula NPI NPI NPI	O
173         173           19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)         173           21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service         B         C. L           21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service         B         C. L           21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service         B         C. L           21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service         B         C. L           21. DIAGNOSIS OF SERVICE         B         C. L         K. L           24. A. DATE(5) OF SERVICE         B         C. D. PROCE         C. D. PROCE           From To         VPUCCOF         EMG         CPT/HCPN           PHORE OF TO         VPUCCOF         EMG         CPT/HCPN           24. A. DATE(5) OF SERVICE         B         C. D. PROCED         C. D. PROCED           From To         VPUCCOF         EMG         CPT/HCPN           24. DATE(5) OF SERVICE         B         D         VY         SERVEC           From To         VPUCCOF         B         C. D. PROCED         C. D. PROCED           25. FEDERAL TAX I.D. NUMBER         SBN EIN         28. PATIENT'S A         C. D. PROCED	INPI	PROM  20. OUTBIDE LAB? 20. OUTBIDE LAB? 22. FEBUGANISSION 23. PRIOR AUTHOR E. F. NOGIS F. NTER CHARGES		TT CORIGINAL I MBER PHY ID. PHY ID. PHY ID. PHY ID. NPI NPI NPI NPI NPI NPI NPI NPI	O

07/19/17 09/28/15

## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

### **PAGE(S) 32**

### 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 – <u>not adjusted or voided</u>.

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.

## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

#### **PAGE(S) 32**

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.

## **PAGE(S) 32**

07/19/17

09/28/15

## Sample of a Claim Form Adjustment with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

HEALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0 PICA		PICA
	MPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG mber ID#) (ID#) (ID#) (ID#)	1a. INSURED'S I.D. NUMBER         (For Program in Item 1)           1234567890123         1234567890123
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OU, JANNIE	06 19 85 M F X	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY ST.	ATE 8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Indude Area Code)
. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	( ) 11. INSURED'S POLICY GROUP OR FECA NUMBER
		a INSURED'S DATE OF BIRTH SEX
I. OTHER INSURED'S POLICY OR GROUP NUMBER IPL Code if applicable	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH SEX MM DD YY M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	<b>SANDLE</b>	
RESERVED FOR NUCC USE	a OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
I. INSURANCE PLAN NAME OR PROGRAM NAME		A IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLI	TING & SIGNING THIS FORM	VES NO If yes, complete items 9, 9a and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authori to process this claim. I also request payment of government benefits of below.</li> </ol>	ze the release of any medical or other information necessary	<ul> <li>payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ul>
SIGNED	DATE	SIGNED
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15.OTHER DATE MM DD YY QUAL	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 71b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-I	to service line below (24E) ICD Ind 9	22. RESUBMISSION CODE ORIGINAL REF. NO.
А. 1 V2501 В. 1	C D.	A 99 4090145678600
	G H	23. PRIOR AUTHORIZATION NUMBER
E F		
I J		
I J 24. A. DATE(S) OF SERVICE B. C. D.P From To PLACE OF	K. L. L. L. K. ROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS (Explain Unusual Circumstances) (THCPCS M. MODIFIER POINTER	F. G. H. I. J. DAYS (1990) ID. RENDERING OR Family QUAL, PROVIDER ID.#
I. J.	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS	\$ CHARGES OF Prior UNITS Prim UNITS Prim CLAL. PROVIDER ID. # 1236548
J. J	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS THOPCS MODIFIER POINTER	S CHARGES         DA'Ss UNITS         Provider Frank Prev Prev UNITS         RENOFERING Frank Prev UNITS         RENOFERING Prev UNITS           1236548         1236548         1236549875
I. J.	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS THOPCS MODIFIER POINTER	DA'IS         Perior Family New Pack         DL Column Out         RENDERING PROVIDER ID.#           1236548         1236549875           150         00         1         NPI         1236549875
I. J.	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS THOPCS MODIFIER POINTER	S CHARGES         DA'Ss UNITS         Provider Frank Prev Prev UNITS         RENOFERING Frank Prev UNITS         RENOFERING Prev UNITS           1236548         1236548         1236549875
I. J.	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS THOPCS MODIFIER POINTER	DA'IS         Perior Family New Pack         DL Column Out         RENDERING PROVIDER ID.#           1236548         1236549875           150         00         1         NPI         1236549875
I. J.	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS THOPCS MODIFIER POINTER	CHARGES         DA'IS Immunity (MITS)         Previor Immunity (MITS)         D. Immunity (MITS)         RENDERING (MITS)         RENDERING (MITS)           1236548         1236548         1236549875         1236549875           NPI         NPI         1236549875         NPI
I. J.	ROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances) DIAGNOSIS THOPCS MODIFIER POINTER	S CHARGES         DA'IS (MITS)         Previous France (MITS)         DL (MITS)         RENDERING France (MITS)         RENDERING (MITS)           150         00         1         NPI         1236548           150         00         1         NPI         1236549875           Image: State of the state of th
I.     J.       24. A.     DATE(S) OF SERVICE       From     B.       C.     D.P.       MM     DD       YY     MM       DD     YY       MM     DD       YY     SERVICE       B.     C.       D.P.       MM     DD       YY     SERVICE       B.     C.       D.P.       B.     C.       D.P.       B.     C.       D.P.       B.     C.       D.P.       B.       C.       D.P.       B.       D.P.       Service       B.       D.P.       D.P.       Service       B.       D.       D. <td>NOCEDURES, SERVICES, OR SUPPLIES     ICrotent Unusual Circumstances)     MODIFIER     DIAGNOSIS     MODIFIER     1015     1</td> <td>CHARGES         DA'IS (MIRS)         PROVIDEN G (MIRS)         PROVIDEN G (MIRS)         PROVIDEN G (MIRS)           1236548         1236548         1236548         1236549875           150         00         1         NPI         1236549875           NPI         NPI         1236549875         1236549875           NPI         NPI         NPI         1236549875           NPI         NPI         1236549875         1236549875           NPI         NPI         1236549875         1236549875           1         NPI         NPI         1236549875           28. TOTAL CHARGE         29. AMOUNT PAID         30. BALANCE DUE</td>	NOCEDURES, SERVICES, OR SUPPLIES     ICrotent Unusual Circumstances)     MODIFIER     DIAGNOSIS     MODIFIER     1015     1	CHARGES         DA'IS (MIRS)         PROVIDEN G (MIRS)         PROVIDEN G (MIRS)         PROVIDEN G (MIRS)           1236548         1236548         1236548         1236549875           150         00         1         NPI         1236549875           NPI         NPI         1236549875         1236549875           NPI         NPI         NPI         1236549875           NPI         NPI         1236549875         1236549875           NPI         NPI         1236549875         1236549875           1         NPI         NPI         1236549875           28. TOTAL CHARGE         29. AMOUNT PAID         30. BALANCE DUE
1.         J.         J.         J.           24. A. DATE(S) OF SERVICE From MM DD YY MM DD YY BERVICE MG CP         B. C. D.P. PLACE OF EMG CP         D.P. EMG CP           03         02         14         03         02         14         11         T           1         1         1         1         T         1         1         T           25. FEDERAL TAX ID. NUMBER         SSN EIN         28. PATE         29. PATE         23. SERVICE         32. SERVICE	CCCEDURES, SERVICES, OR SUPPLIES  (Explain Unusual Circumstances)  THOPCS  MODIFIER  1015	CHARGES         DA'IS (MITS)         PROVIDER IG Francy (MITS)         PROVIDER IG (MITS)          PROVIDER IG (MIT
I.         J.         J.           24. A.         DATE(S) OF SERVICE         B.         C.         D.P.           From         MM         DD         YY         BBRVICE         EMG         CP           03         02         14         03         02         14         11         T           I         I         I         I         I         I         I         I           I         I         I         I         I         I         I         I         I           I	NCCEDURES, SERVICES, OR SUPPLIES (Erclain Unusual Circumstances) InCrCCS MODIFIER 1015	CHARGES         DA'IS (MIRS)         PROVIDEN G (MIRS)         PROVIDEN G (MIRS)         PROVIDEN G (MIRS)           1236548         1236548         1236548         1236549875           150         00         1         NPI         1236549875           NPI         NPI         1236549875         1236549875           NPI         NPI         NPI         1236549875           NPI         NPI         1236549875         1236549875           NPI         NPI         1236549875         1236549875           1         NPI         NPI         1236549875           28. TOTAL CHARGE         29. AMOUNT PAID         30. BALANCE DUE
I.         J.         J.         J.           24. A.         DATE(S) OF SERVICE         B.         C.         D.P.           From         TO         YPLACE OF         EMG         C.         D.P.           MM         DO         YY         MM         DO         YY         BEVICE         EMG         C.         D.P.           03         02         14         03         02         14         11         T           I	NCCEDURES, SERVICES, OR SUPPLIES (Erclain Unusual Circumstances) InCrCCS MODIFIER 1015	BAYS         PROVIDER ING Freed UNITS         RENDERING Freed UNITS         RENDERING Freed UNITS         RENDERING Freed UNITS           150         00         1         NPI         1236549875           NPI         1236549875         NPI         1236549875           NPI         NPI         130. BALANCE DUE           S         150         00         1         1           33. BILING PROVIDER INFO & PH#         (225) 555-4957         1           Always Open RHC/FQHC         1         1         1

RURAL HEALTH CLINICS

PAGE(S) 32

07/19/17

09/28/15

## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

## Sample of a Claim Form Adjustment with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

EALTH INSURANCE CLAIM FORM										
	14000) 0212									
1. MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP HEALTH PLA	FECA N BLKLUNG	OTHER	1a. INSURED:	S I.D. NUM	BER	(	For Program	in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#)	(Member ID#	i) (ID#)	(ID#)	(IDII)	12345678	90123				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	)	MM DD			4. INSURED'S	NAME (La	ist Name,	First Name, Mid	de Initial)	
LOU, JANNIE 5. PATIENT'S ADDRESS (No., Street)		06 19 3. PATIENT RELATI	85 M	F X	7. INSURED'S	ADDDECC	Alo Ch	m. cf)		
PATIENT S ADDRESS (NO., STREE)		Self Spouse		ther	7. INSUNED'S	ADDINES	s (rea., on	looy		
лтү	STATE 8	RESERVED FOR			CITY				s	TATE
1P CODE TELEPHONE (Indude Are	sa Code)				ZIP CODE			TELEPHONE (In	clude Area Co	ode)
LOTHER INSURED'S NAME (Last Name, First Name, Midd	(leitin)	10. IS PATIENT'S C		ED TO:	11 INSURED		GROUP	( ) DR FECA NUMB	ED	
COTTER INSORED'S INNIR (Last Name, Filst Name, Mild	ure inneait)	IU. IS PATIENT SU	ONDITION RELATI	ED 10.	TI. INSURED	SPOLICI	GROUP	UK PEUK NUMB	ER	
OTHER INSURED'S POLICY OR GROUP NUMBER		. EMPLOYMENT? (	Current or Previous	)	a. INSURED	S DATE O	F BIRTH		SEX	
TPL Code if applicable		YE	S NO					м		F
RESERVED FOR NUCCUSE	1	AUTO ACCIDENT	7 PL/	ACE (State)	b. OTHER CLA	MID (Der	signated b	y NUCC)		
RESERVED FOR NUCC USE		SAR	<b>MP</b>	F	C INSURANCE		ME OR F	ROGRAM NAMI	-	
REGERVED FOR NUCC USE	4				G. INSURANCI	- FUAN NA	URE OR F	NOGRAM NAME	-	
INSURANCE PLAN NAME OR PROGRAM NAME		YE IOL RESERVED FO	IN LOCAL USE		d. IS THERE A	NOTHER	HEALTH	BENEFIT PLAN?	,	
- 1						N	_	es, complete iten		9d.
READ BACK OF FORM B	- W - N a	G IN THIS FO			1. INS IRF /	SOR UT	OF ZED	PERSON'S SIG	NATURE Lau	thorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATORE to process this claim. I also request payment of government</li> </ol>	t benefits either to	wase of any means myself or to the party	who accepts assign	ment	payment of services de	measure be	invenits to r low.	the undersigned	physician or s	supplier for
below. SIGNED		DATE								
GIGHED										
A DATE OF CURRENT 11 NECK IN URV. or DRECMANC	WALKER LAB OT				SIGNED			WORK IN CLIPS	ENT OCCUR	DATION
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANC		HER DATE		, ,	16. DATES PA		ABLE TO YY	WORK IN CURF		PATION YY
A DATE OF CURRENT ILLNESS, INJURY, & PREGNANC MULE QUAL 7. NAME OF REFERRING PROVIDER OR OTHER SOURC	QUAL	HER DATE		,	16. DATES PA MN FROM	TIENT UN		10		
QUAL	QUAL CE 17a	HER DATE	IM DD YY	,	16. DATES PA MN FROM	TIENT UN		WORK IN CURP TO LATED TO CUR TO		
QUAL	QUAL OE 17a. 71b. 1	HER DATE	IM DD YY	,	16. DATES PA MN FROM 18. HOSPITAL	TIENT UN DD IZATION D			RENT SERVI	
QUAL 7. NAME OF REFERRING PROVIDER OR OTHER SOURC 9. ADDITIONAL CLAIM INFORMATION (Designated by NU	QUAL CE 17a 71b 1 JOC)	NPI		,	16. DATES PA MM FROM 18. HOSPITAL FROM 20. OUTSIDE I	ITIENT UN DD IZATION D DD IAB?	ATĘS RE	LATED TO CUR TO	RENT SERVI	
QUAL 7. NAME OF RÉFERRING PROVIDER OR OTHER SOURC 9. ADDITIONAL CLAIM INFORMATION (Designated by NU 1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	QUAL OE 17.a. 71b. 1 JOC) Relate A-L to serv	HER DATE	ICD Ind. 0	,	16. DATES PA MM FROM 18. HOSPITAL MM FROM 20. OUTSIDE I	IZATION D IZATION D LAB? NC		TO LATED TO CUR TO \$ CHARGE DRIGINAL REF.	RENT SERVI	
QUAL         QUAL           7. NAME OF RÉFERRING PROVIDER OR OTHER SOURCE         9. ADDITIONAL CLAIM INFORMATION (Designated by NU           9. ADDITIONAL CLAIM INFORMATION (Designated by NU         1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY         1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY           A. JZ30011         B. L	QUAL CE 17a. 71b. 1 JOC) Relate A-L to serv C.	NPI	ICD Ind. 0	,	16. DATES PA MA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBMIS CODE			TO LATED TO CUR TO \$ CHARGE ORIGINAL REF. 299198798	RENT SERVI	
QUAL 7. NAME OF RÉFERRING PROVIDER OR OTHER SOURC 9. ADDITIONAL CLAIM INFORMATION (Designated by NU 1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	QUAL CE 17a. 71b. 1 JCC) Relate A-L to serv C. L G. L	HER DATE N	ICD Ind. 0	,	16. DATES PA MM FROM 18. HOSPITAL FROM 20. OUTSIDE I			TO LATED TO CUR TO \$ CHARGE ORIGINAL REF. 299198798	RENT SERVI	
QUAL     QUAL     QUAL     QUAL     QUAL     CAME OF REFERRING PROVIDER OR OTHER SOURCE     A ADDITIONAL CLAIM INFORMATION (Designated by NU     DIAGNOSIS OR NATURE OF ILLNESS OR INJURY     A. JZ30011     B EF LF     LJ     LJ     LJ	QUAL CE 17a 71b. 1 JOC) Relate A-L to serv C. L K. D PROCED	HER DATE		E	16. DATES PA MA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBMIS CODE			TO TO S CHARGE ORIGINAL REF. 299198798	RENT SERVI RENT SERVI S NO 3700	1¢\$\$
QUAL     QUAL     QUAL     QUAL     CONTREME OF REFERRING PROVIDER OR OTHER SOURCE     ADDITIONAL CLAIM INFORMATION (Designated by NU     DIAGNOSIS OR NATURE OF ILLNESS OR INJURY     A. [230011]     B. [     F. [     F. [     G. [200011]     CONTREME OF SERVICE	QUAL CE 17a 71b. 1 JOC) Relate A-L to serv C. L K. D PROCED	HER DATE			16. DATES PA MA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBMIS CODE			TO TO S CHARGE CORIGINAL REF. 299198798 IBER	RENT SERVI DD S 700 PROVID	
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L           7. NAME OF REFERENCE           8. L           9. L           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. L           1. L           1. L           2. L           1. L           2. L           3. L           4. A. DATE(S) OF SERVICE           1. M. DD           3. VY           MM           DD           4. A. SATE(S) OF SERVICE	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			LATED TO CUR TO \$ CHARGE 299198798 IBER H H L L L L L L L L L L L L L L L L L	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L           7. NAME OF REFERENCE           8. L           9. L           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. L           1. L           1. L           2. L           1. L           2. L           3. L           4. A. DATE(S) OF SERVICE           1. M. DD           3. VY           MM           DD           4. A. SATE(S) OF SERVICE	QUAL CE 17a 71b. 1 JOC) Relate A-L to serv C. L K. D PROCED	HER DATE		E. DIA GNOSIS	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			LATED TO CUR TO \$ CHARGE 299198798 IBER H H L L L L L L L L L L L L L L L L L	RENT SERVI DD S 700 PROVID	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L         F.           6. L         F.           6. L         F.           6. L         J.           7. NAME OF SERVICE         B.           6. L         J.           7. NAME OF SERVICE         B.           1. L         DATE(S) OF SERVICE           1. M. DD         YY	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			LATED TO CUR TO \$ CHARGE 299198798 IBER H H L L L L L L L L L L L L L L L L L	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L         F.           6. L         F.           6. L         F.           6. L         J.           7. NAME OF SERVICE         B.           6. L         J.           7. NAME OF SERVICE         B.           1. L         DATE(S) OF SERVICE           1. M. DD         YY	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			ALATED TO CUR TO \$ CHARGE ORIGINAL REF. 299198798 IBER H L DRIGINAL REF. 299198798 IBER H L DRIGINAL REF. 299198798	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L         F.           6. L         F.           6. L         F.           6. L         J.           7. NAME OF SERVICE         B.           6. L         J.           7. NAME OF SERVICE         B.           1. L         DATE(S) OF SERVICE           1. M. DD         YY	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			ALATED TO CUR TO \$ CHARGE ORIGINAL REF. 299198798 IBER H L DRIGINAL REF. 299198798 IBER H L DRIGINAL REF. 299198798	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L         F.           6. L         F.           6. L         F.           6. L         J.           7. NAME OF SERVICE         B.           6. L         J.           7. NAME OF SERVICE         B.           1. L         DATE(S) OF SERVICE           1. M. DD         YY	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			IO IO IO IO IO IO IO IO IO IO	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           8. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6. L         F.           6. L         F.           6. L         F.           6. L         J.           7. NAME OF SERVICE         B.           6. L         J.           7. NAME OF SERVICE         B.           1. L         DATE(S) OF SERVICE           1. M. DD         YY	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			IO IO IO IO IO IO IO IO IO IO	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           9. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6.   Z30011         B.	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			IO IO IO S CHARGE 299198798 BBER Harr L NPI 12 NPI 12 NPI 12	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           9. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6.   Z30011         B.	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			IO IO IO IO IO IO IO IO IO IO	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           9. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           6.   Z30011         B.	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE		E. DIA GNOSIS POINTER	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG			IO IO IO S CHARGE 299198798 BBER Harr L NPI 12 NPI 12 NPI 12	RENT SERVI RENT SERVI 33 35 700 36548	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           9. ADDITIONAL CLAIM INFORMATION (Designated by NU           10. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           10. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           10. ADJOTIONAL CLAIM INFORMATION (Designated by NU           10. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           10. ADJOTIONAL CLAIM INFORMATION (Designated by NU           10. ADJOTIONAL CLAIM INFORMATION (DESIGNATION (DES	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED (Explain C) S. CPT/HCPC	HER DATE s IPI IPI IPI IPI IPI IPI IPI IPI IPI IP	ICD Ind. 0	E DIA GNOSIS POINTER A	16. DATES PA FROM 18. HOSPITAL FROM 20. OUTSIDE I YES 22. RESUBME CODE 23. PRIOR AU F. \$ CHARG	TTENT UNIT	ATES RE 2 5. 1 5. 100 NUM 0075 1 100 NUM	IO IO IO IO IO IO IO IO IO IO	REND REND	ERING ERING
QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE           9. ADDITIONAL CLAIM INFORMATION (Designated by NU           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           1. DAGNOSIS OR NATURE OF ILLNESS OR INJURY           4. <u>Z30011</u> 8. <u>L</u> 6. <u>DAGNOSIS OR NATURE OF ILLNESS OR INJURY</u> 1. <u>J</u> 4. A. DATE(S) OF SERVICE           4. A. DATE(S) OF SERVICE           5. FROM           10           10           10           10           10           10           10           10           10           10           10           10           10           10           10           10           10           11           11           11           11           11           12           13           14           15           16           17           18           19           19           10           10	QUAL CE 17a 71b 1 JOC) Relate A-L to serv C. L K. L D.PROCED D.PROCED I. T1015	HER DATE s IPI IPI IPI IPI IPI IPI IPI IPI IPI IP	ICD Ind. 0	E DIA GNOSIS POINTER A	16. DATES PAR FROM 18. HOSPITAL PROM 20. OUTSIDE I YES 22. PRESUBAR 23. PRIOR AU F. \$ CHARG 160	TTENT UNIT		IO IO IO IO IO IO IO IO IO IO	REND REND	ERING ERING 5
QUAL         QUAL           7. NAME OF REFERRING PROVIDER OR OTHER SOURCE         9. ADDITIONAL CLAIM INFORMATION (Designated by NU           9. ADDITIONAL CLAIM INFORMATION (Designated by NU         1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY         1           1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY         8. [	QUAL OE 17a. 71b. 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED C.PROCED C.PROTOCED C.P	HER DATE s IPI IPI IPI IPI IPI IPI IPI IPI IPI IP	ICD Ind 0	E DIA GNOSIS POINTER A	16. DATES PAR FROM 18. HOSPITAL PROM 20. OUTSIDE I YES 22. RESUBUR 23. PRIOR AU F. \$ CHARG 160 24. TOTAL O \$ 33. BILLING I	THENT UN.N.T		IO IO IO IO IO IO IO IO IO IO IO IO IO I	Image: state	ERING ER ID. # 5 5 NCE DUE 160 00
QUAL     QUAL	QUAL OE 17a. 71b. 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED C.PROCED C.PROTOCED C.P	HER DATE S IPI CONTROL STATES	ICD Ind 0	E DIA GNOSIS POINTER A	16. DATES PAR FROM 18. HOSPITAL 18. HOSPITAL 18. HOSPITAL 19. EXEMPTION 10. HOSPITAL 12. PRIOR AU 1. SCHARG 1. SC			IO IO IO IO IO IO IO IO IO IO IO IO IO I	Image: state	ERING ER ID. # 5 5 NCE DUE 160 00
CUAL     OUAL     OUAL     CAME OF REFERRING PROVIDER OR OTHER SOURCE     ADDITIONAL CLAIM INFORMATION (Designated by NU     DAGNOSIS OR NATURE OF ILLNESS OR INJURY     A     CAGNOSIS OR NATURE OF ILLNESS OR INJURY     A     CAGNOSIS OR SUPPLY	QUAL OE 17a. 71b. 1 JOC) Relate A-L to serv C. L G. L K. L D.PROCED C.PROCED C.PROTOCED C.P	HER DATE S IPI CONTROL STATES	ICD Ind 0	E DIA GNOSIS POINTER A	16. DATES PAR FROM 18. HOSPITAL PROM 20. OUTSIDE I YES 22. RESUBUR 23. PRIOR AU F. \$ CHARG 160 24. TOTAL O \$ 33. BILLING I	THENT UNAN INFORMATION OF A CONTRACT OF A CO	ATES RE 2 5. 1 5. 1 10N NUW 0 0 1 0 0 0 0 1 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	IO IO IO IO IO IO IO IO IO IO	Image: state	ERING ER ID. # 5 5 NCE DUE 160 00

## CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

### **PAGE(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:

Molina Medicaid Solutions 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 Molina Medicaid Solutions should never include radiographs.
2	Predetermination / Preauthorization Number	<b>Situational</b> – 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)	<b>Required</b> 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	<b>Required</b> Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS.	
15	ID	Do not use the 16-digit Card Control Number (CCN) from the recipient's Medicaid card.	
16	Plan / Group Number	Situational.	
17	Employer Name	Situational.	
18	Relationship to Policyholder/Subscriber in #12 above.	Situational.	
19	Student Status	Situational.	
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Situational. This field should be used only when other private insurance is primary. 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)	<b>Optional</b> – 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	
24	Procedure Date (MM/DD/CCYY)	characters. <b>Required</b> 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.	

## PAGE(S) 32

07/19/17

09/28/15

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> enter an oral cavity designator in Block 25.	Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
28	Tooth Surface	Situational – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: 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.	

Locator #	Description	Instructions	Alerts
29	Procedure Code	<b>Required –</b> 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	<b>Required –</b> Enter the description of the service performed.	
31	Fee	<b>Required</b> 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)	<ul> <li>Situational – Complete if applicable.</li> <li>Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".</li> <li>In the following circumstances, this information is required:</li> <li>If the claim is for the Adult Denture Program.</li> <li>If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy.</li> </ul>	

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 <b>required</b> 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 <b>required</b> 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	Diago of Transferent	<b>Situational</b> – 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 <b>required</b> .	
		Situational – Enter 00 to 99 in applicable boxes.	
39	Number of Enclosures	Claims submitted for prior authorization are <b>required</b> 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 Treatment for Orthodontics?	Claims requesting comprehensive orthodontic services are <b>required</b> 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	Replacement of Prosthesis	Situational – Check appropriate box if applicable; if checked, complete Block 44 if known.	
44	Date Prior Placement	Situational – If Block 43 is checked and if known, enter the appropriate 8-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	<b>Situational</b> – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is <b>required</b> . 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	<b>Situational</b> . If Auto Accident is checked in Block 45, this block is <b>required</b> . Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	<b>Required</b> . 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	<b>Required</b> Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	<b>Required</b> – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	
53	Signature	Optional.	
54	NPI	<b>Optional</b> – Enter the 10-digit NPI of the treating (attending) dental provider	
55	License Number	<b>Required</b> – Enter the license number of the treating (attending) dental provider.	

Locator #	Description	Instructions	Alerts
56	Address, City, State, Zip Code	<b>Situational</b> – 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	<b>Optional</b> – Enter the 10-digit NPI of the treating (attending) dental provider	

## **PAGE(S) 32**

## Sample of ADA Claim Form

ADIA. Dental Claim	Forn	n									/ISA 07-02	
HEADER INFORMATION											achment 1	
1. Type of Transaction (Mark all applic		_										
Statement of Actual Services		Reques	t for Predel	termination	/Preauthorizatio	99						
EPSDT/Title XIX     Predetermination/Preautholization												
123456789	Number						POLICYHOLDE 12. Policyholder/St					
INSURANCE COMPANY/DENT/			N INFOR				_		as, res, waar	near, control, Mode	ess, ceg, cene, c	, COM
3. Company/Plan Name, Address, City			AN INFOR	MATION			Brown,	Wade				
a companyo na manu, manuan, co	y, waan, m						8269 CI	hilly Rd				
							Winter.	LA 7000	0			
							13. Date of Birth (N	MDD/CCYY)	14. Gender	15. Policyhok	der/Subscriber ID	(SSN or ID#)
							08/14/20	04	X <sup>™</sup> □	12345	6789012	3
OTHER COVERAGE	_			_			16. Plan/Group No	mber	17. Employer Nar	10		
4. Other Dental or Medical Coverage	-	4o (Skip!		And .	Complete 5-11)							
5. Name of Policyholder/Subscriber in	1 #4 (Last,	First, Mid	die Initial, S	laffix)			PATIENT INFOR					
	7. Gende				scriber ID (SSN)	11 ID 41	18. Relationship to	Spouse			19. Student S	PTS
6. Date of Birth (MM/OD/CCYY)	7. Gener		a rouch		Press of Cooler	(* 1,04)	20. Name (Last, Fi					C160
9. Plan/Group Number			ionship to P	Person Nar	ned in #5		es. mane qualit, Pr			-y, 5489, 24 COD	-	
TPL Carrier Code						Ther						
11. Other Insurance Company/Dental												
							21. Date of Birth (N	MCO/CCYY)	22. Gender		Account # (Assig	hed by Dentist)
										;		
RECORD OF SERVICES PROV	1						-					
24. Procedure Date 25. Am (MMODICCYY) Cruck	a 25 a Tooth	27.1	footh Numb or Letter(s)	Hen(S)	28. Tooth Surface	29. Proced Code	19		30. Description			31. Fee
1/14/12	y System					0000	9 Encou	inter - Al	Unclusio	/0		100 00
2 1/14/12 <b>10</b>	+ +					D434	9 Encou 1 Period	Iontal Sc	aling an	d Root P	laning	110 00
1/14/12		13				D295	4 Post &	Core	anng an	u noot r	Taring	94 00
1/14/12		15				D293	1 Stainle	ss Steel	Crown			140 00
5												
6												
7												
8							_					
9												
MISSING TEETH INFORMATIO					Remover		_		0.0		1	
		2 3	4 5	6 7	8 9 10	11 12	13 14 15 16	A B C		ніј	32. Other Fee(3)	
34. (Place an X on each missing lock	N 32						20 19 18 17			MLK	33.Total Fee	444 00
35. Remarks												
If TPL invo	lved	: writ	te the	wore	ds "Car	rier Pa	aid" and e	enter the	amoun	paid by	the TPL	here.
AUTHORIZATIONS							ANCILLARY CO		ENT INFORMA			
35. I have been informed of the treatm charges for dental services and make the treating dentist or dental practice such charges. To the entient permitted information to carry out payment activ	nent plan a rials not pe	and associated by my-	lated fees. I dental bene	l agree to b Ht plan, uni	e responsible to less prohibited b	or all by law, or	58. Place of Treats			39. Num Fact	nber of Enclosurer reproto: Drailing	s (00 to 99) miai Modelini
the treating dentist or dental practice i such charges. To the extent permitted	has a cont I by law, I c	ractúal ág consent to	your use a	th iny plan nd disclose	prohibiting all or are of my protect	a portion of ted heath		Office Hospita	# ECF	Other L		
information to carry out payment activ	ribits in con	nection v	with this clas	m			40. Is Treatment to				opliance Placed (	MMD0/CCYY)
X Patient/Guardian signature				Dat	-			11-42) Yes			New Discourses of	1000000
							42. Months of Trea Piernaining		Yes (Complete	1445	nut maxement (A	mouro(611)
37. Thereby sufficize and direct payment dentical or dential entity.	t of the deni	bi benefits	otherwise pr	sysble to me	, directly to the be	row named	45. Treatment Res					
							_	nal illness/injury	Auto	accident [	Other accident	
X Bubscriber signature				Date	0		45. Date of Accide		)		47. Auto Acciden	
BILLING DENTIST OR DENTAL	ENTITY	(Leave)	olanik il deri	tist or dents	al entity is not su	iomitting	TREATING DEP					
claim on behalf of the patient or insur-	1510501	Ner)				-	53. I hereby certify violatio or have been	that the procedures	as indicated by da	te are in progress (f	for procedures that	require multiple
48. Name, Address, City, State, Zp O										_		
XYZ Dental Group							X Signed (Treating C	ary Clea	nceen	<u> </u>	/14/12	
8956 No Cavity Ave.										11 million 1	Date	
Smiley, LA 70000	0						54. NPP1234			License Number	99999	
49. NPI 50	I BARRER A	Magnet and		51. SSN	or Tabl		55. Address, City,	coate, 20 Code	Sp	<ul> <li>Providet sciałty Code</li> </ul>		
1987654321	). Uxense 1	-vamoer		91.994	- 18 <b>4</b>							
52 Prote (222)999-4	444	1	SZA Additio	nel 41	34567		57. Phone (	) -	58	Additional Provider ID	987654	
© 2006 American Dental Ass			10/10	KU 14	.04007		WINDER 1	, .		P HOMBER RD	To Receder call 1	-800-947-4746
	rm - 3401.		(1014, 20								or go online at w	ww.adacatalog.ce

© 2006 American Dental Association J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404).

Page 25 of 32

### CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

#### **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	<ul><li>Adjust - Enter the information exactly as it appeared on the original invoice.</li><li>Void - Enter the information exactly as it appeared on the original invoice.</li></ul>	
5	Medical Assistance ID Number	<ul> <li>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.</li> <li>Void - Enter the information exactly as it appeared on the original invoice.</li> </ul>	
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.	<ul> <li>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.</li> <li>Void – Enter the information exactly as it appeared on the original invoice.</li> </ul>	
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	Request for Prior Authorization	Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.	
32	Attending Dentist's Provider Number	The provider number must be entered.	

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

# PAGE(S) 32

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

						Patie	nt ID/Account Number			
FOR PREAUTHORIZATION MARL TO: LSU SCHOOL OF DENTISTRY MIDICIDE DIRTA: PROBLEM MIDIOLIDE DIRTA: PROBLEM MIDIOLIDE DIRTA: PROBLEM MIDIOLIDE DIRTA: PROB MIDIOLIDE DIRTA MIDIOLIDE DIRTA	FOR PAYMENT REMIT TO: Nolina Medicab R.O. BOX 91022 BATON ROUGL, UA (800) 473-2783 (225) 924-3040	d Solutions	BUREAU OF MEDIC	TE OF LOUISI OF HEALTH AN HEALTH SERVICES AL ASSISTANCE PR COVIDER BILLING PO SDT DENTAL SERVI	FINANCING OGRAM OR				LE	
TABLENTS LAST NAME (HEN)			FIRST NAME		/		MEDICAL ASSISTANCE LD. N			_
Smith			Sally			L	1 2 3 4 5		0 1 2	3
PATIENT'S ADDRESS (STREET HUME							02 15	2002 C		F
BRITERING AGENCY NO.	DO DATE O	F REFERENCE	EMER	GENO SCIEDNING	NAME .		>			
T HEFERRID BY (SIGNATURE)	14 19.0%	ONE NO.		SCHEINING	ADDRES					_
			· ·		TEL NO					-
WY TO DENTIST OR GROUP				1800000	SKOUP MOVIDER	40.	VES NO			
NAME				REALMENT NO.2555	A 100-071	YES	NUMBER OF X-BATS	AN THE R.R.		-
ADDRESS				A. EMPLOYM	<b>IENT</b>		TH, GARRER-CODE:			
CITY	ST	ZP		B. ACCIDEN	T/INUURY	I YES	1			-
P ROSTHESS, 5 THS THE INITIAL PLACEMENTS	YES 2	IF ADULT EMBRO	NCY SERVICE.			2.00	2			-
	D NO	CHECK BLOCK AN	ID SEND TO OFS	DENTAL PROGRAM			3			-
72		EXAMINATION A	C C	WENT PLAN - UST IN		M TOOTH NO	D. 1 THRU NO. 32 - USE O		HOWN.	-
FACIAL		FOR SURFA	NOCEMBE	DESCR	D. TION OF SERVIC	.	DATE SERVICE PERFORMED	ADAUSTED ME IFOR STATE	USUAL AND	
(OCOC)	200	UTTER	CODE	1000	inter active		UNITS MO. DAY YR	USE CHEY	CUEIOMARY R	-
St Steps		16	D2931	Stainless	Steel Cr	own	02 16 12	1 1	135 0	00
	8.8		K.	01			23 Auto Nava Che	NE BY	s	
240	3 8			-	-					5
RIGHT	INVESTIGATION OF	206119	aumber 8765400		THE IS NOR ITEM, (THE IS NOR ITEM, (THE IS NOR ITEM) OF ADMINISTREE	CHANGING OR V SORECT CONTRA 4 THE REWITTAN AMED (	CENC A MAD CE NUMBER AS MCE ADVICE IS 03/1	6/2012	4	
		REASONS P	OR ADJUSTMEN	ধা		B	illed wrong toot	h # should		
		01	THIRD PARTY I	ABILITY RECOVERY			tooth #16, not			
FACIAL		02	PROVIDER CO							-11
A. INK IN RESTORAT B. INDICATE MISSIN		H %	FISCAL AGEN STATE OFFICE	USE ONLY - RECOV	ERY					_
WITH AN-X.		1 99	OTHER - PLEAS	SE EXPLAIN						_
C. INDICATE CROWN AN-O.	NS WITH								_	_
D. INDICATE TEETH T EXTRACTED WITH		20 REASONS F	OR VOID							
REMARKS FOR UNUSUAL	SERVICE					_				-1
				R WRONG RECIPIEN		_			_	-1
			CLAIM PAID TO OTHER - PLEAS	WRONG PROVIDE	R	-				-
			UNITER - FIEAS	C LATURE		_				_
										_
I HAVE READ THE CERTIFIC	ATION ON THE REV SEND TO OPS DENTAL	RESE OF THIS FORM		CERTIFY THAT I AM IN						-
			APP	IOVED - YES	NO	/EXCEPTION		Smilley, DDS		_
ATTENDA	G DENTSPS SIGNATUR	4	PA	123456780			18888		/05/2012	
RONDERHUMBER		648	AUHORZ	D SCHATURE			DAT	NOVERTILINE		-
									MOLIN	A-209

## **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	<ul> <li>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.</li> <li>Void - Enter the information exactly as it appeared on the original invoice.</li> </ul>	
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	<ul> <li>Adjust – Enter the information exactly as it appeared on the original invoice.</li> <li>Void - Enter the information exactly as it appeared on the original invoice.</li> </ul>	
17	Pay to Dentist or Group Provider No.	<ul> <li>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.</li> <li>Void – Enter the information exactly as it appeared on the original invoice.</li> </ul>	
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	Request for Prior Authorization	Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization,	
32	Attending Dentist's Provider Number	The provider number must be entered.	

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

## 07/19/17 09/28/15

### CHAPTER 40: RURAL HEALTH CLINICS APPENDIX D: CLAIMS FILING

## **PAGE(S) 32**

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

			Patient ID/Account Number				
FOR PREAUTHORIZATION         FOR PAYMENT REAL           US USDOD, OF DEVITE/TH MEDICLE DEVIT, PROGRAM DEVICE DEVIT, PROGRAM DEVICE DEVIT, PROGRAM DEVICE DEVIT, PROGRAM DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE NOT REAL DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE DEVICE D	Id Solutions DEPARTMENT ( BUREAU OF HE 0R1 MEDICAL PRO	TE OF LOUISIANA OF HEALTH AND HOSPITALS EALTH SERVICES FINANCING ASSISTANCE PROGRAM VIDER BILLING FOR IT DENTAL SERVICES	SAM	PLE			
PATIENT'S LAST NAME (PRINT)	E FIRST NAME	p.	MEDICAL ASSISTANCE I.D. N.				
Que	Susie			7890123			
PATIENTS ADORESS (STREET NUMBER, CIT	Y, STATE, ZIP CODE) (TEL. NO.)		DATE OF BIRTH 06 19 1955				
REFERRING AGENCY NO.	ATE OF REFERINAL	22 DENTIST OR GRO NAME					
ER REFERRED BY: (SIGNATURE) ET TELEPHONE NO. ER INTERED ACCOURT HEIGHEID FORET							
PAY TO DENTIST OR GROUP		TEL. NO.	NO. ARE X-RAYS ENCLOSED?				
F		1800000	YES NO				
NAME		IN TREATMENT NECESSITATED BY:	PAYMENT SOURCE OTHER T	HAN TITLE XIX			
ADDRESS		A. EMPLOYMENT YES TPL CAMIER CODE:					
CITYST.	ZP	□ N0 1					
# PROSTHESIS, IS THIS THE INITIAL PLACEMENT?	YES NO	B. ACCIDENT/INJURY					
12	A PROCEDURE B.	DESCRIPTION OF SERVICE	C-DATE SERVICE D-ADJUST PERFORMED en ISET	TED FEE E. USUAL AND CUSTOMARY FEE			
BICAS,		nter All Inclusive	01120112	125 00			
COOOOO	F. ORAL	G. TOOTH	PAD O				
¢ Q	CAVITY		OTHER	CARRIER			
The PATENT EDENTULOUS?							
IMBURL 1100 MAXILLARY: NO YES DATE OF LAST EXTRACTIONS							
- Almon	(2) DOES PATIENT PRESENTL		DATE OF PLACEMENT.				
NGHT LEFT &	MAXILLARY: NO	YES FULL PARTIAL					
LOWER	MANDIBULAR: NO	YES FULL PARTIAL					
0°				-			
ö	COMMENTS:						
00000							
INCOM. INFORMATION FROM PATIENT							
		YEAR WAS YOUR LAST DENTURE MADE	P UPPER	_ LOWER			
(2) NAME AND ADDRESS OF DENTIST INDICATE TEETH TO BE (3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES NO							
EXTRACTED WITH A/.							
INDICATE MISSING TEETH WITH AN X.	2131198765400	THIS IS FOR CHANGING TRIM, THE CONVECT CO SHOWN ON THE REAT ALMAYS FEICURED)	OR VOIDING A PAID WTHOL NUMBER AS TRANCE ADVICE IS 05/18/1	-			
	REASONS FOR ADJUSTME		Billed wrong charge arr	ount			
	01 THIRD PARTY LIA	BLITY RECOVERY					
SKETCH IN DESIGN OF PARTIAL DENTURE	02 PROVIDER CORP 03 FISCAL AGENT E	approvides consections     Initially billed \$12.50 instead of					
TO BE CONSTRUCTED INDICATING TEETH		SE ONLY - RECOVERY	\$125.00				
TO BE REFLACE AND 90 STATE OFFICE USE ONLY - RECOVERY 90 OTHER - PLEASE DRYLAN 99 OTHER - PLEASE DRYLAN							
REASONS FOR VOID							
10 CLAM PAID FOR WRONG RECIPIENT							
	11 CLAIM PAID TO WRONG PROVIDER						
99 OTHER-PLEASE EXPLAIN							
1HAVE READ THE CERTIFICATION ON THE REVENUE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.							
Γ	APPROVE	ED YES NO WIEXO		Smiley, DDS			
ATTENONG DENTIGTE GOM	ATORE		188888	DIRATENTATE SOLATONE			
	DATE		100000	B 05/20/12			
PROVODER NOMECH DATE MOLLINA,210 1004							