# 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	<b>Optional</b> – 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.	

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

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

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 <b>required</b> 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.	

09/28/15 04/30/14

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

Locator #	Description	Instructions	Alerts
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable. In the following circumstances, entering the name of the appropriate physician block is <b>required</b> : If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.	
17a	Unlabeled	Leave Blank.	
17b	NPI	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 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         97 = 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	Required Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> Enter the appropriate place of service code for the services rendered.	

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

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

09/28/15 04/30/14

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 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.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<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**

09/28/15

04/30/14

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

IN THE SURANCE CLAIM FORM	0102/42	
	0,02.12	PICA
. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	(Member ID#) (ID#) (ID#) (ID#)	1234567890123
2. 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)
LOU, JANNIE 5. PATIENT'S ADDRESS (No., Street)	06 19 85 M F X	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
лтү	STATE 8. RESERVED FOR NUCC USE	CITY STATE
IP CODE TELEPHONE (Include Area Co		ZIP CODE TELEPHONE (Include Area Code)
	de)	ZIP CODE TELEPHONE (Indude Area Code) ()
OTHER INSURED'S NAME (Last Name, First Name, Middle In	tial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
PL Code if applicable	YES NO	M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE		C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
E	CAMPLE OF IC	d IS THERE ANOTHER HEALTH BENEFIT PLAN? NO If year complete items 9 9a and 9d 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
READ BACK OF FORM BEFORE CO PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 at to process this claim. I also request payment of government ben below.	IPLETING & SIGNING THIS FORM. thorize the release of any medical or other information necessar efits either to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED	DATE	SIGNED
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LI	MP) 15.0THER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
QUAL.	QUAL.	FROM TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	71b. NPI	FROM TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relat	e A-L to service line below (24E) ICD Ind 9	22. RESUBMISSION CODE ORIGINAL REF. NO.
V2501 B.	C D	
E F	G H	23. PRIOR AUTHORIZATION NUMBER
J A. A. DATE(S) OF SERVICE B. C	K. L. L. D.PROCEDURES, SERVICES, OR SUPPLIES E.	
From To PLACE OF M DD YY MM DD YY SERVICE EMG	(Explain Unusual Circumstances) DIAGNOSIS CPT/HCPCS MODIFIER POINTER	CHARGES UNT Paint QUAL. PROVIDER ID. #
TI MIM DO IT GENOLE ENG	or interior modifier Pointer	1236548
3 02 14 03 02 14 11	T1015 A	150 00 1 NPI 1236549875
3 02 14 03 02 14 11	00010	1236548 00 1 NPI 1236549875
3 02 14 03 02 14 11 400703680101 UN150.00 DEPO-ROVER/	99213 A	00 1 NPI 1236549875 1236548
3 02 14 03 02 14 11	J0150 A	00 150 NPI 1236549875
		NPI
1 1 1 1 1 1		
		NPI
		NPI
FEDERAL TAX I.D. NUMBER SSN EIN 26. P.	ATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 150 00 \$ \$
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SI INCLUDING DEGREES OR CREDENTIALS	ERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (225) 555-4957
INCLOUING DEGREES OR OREDENTIALS		Always Open RHC/FQHC
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		123 Main St.
(I certify that the statements on the reverse apply to this bill and are made a part thereof.) GNED Jane Doe, MD DATE 3/9/14 a.	b.	

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

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

EALTH INSURAN												
PROVED BY NATIONAL UNIF	ORM CLAIM C	OMMITTEE (N		GROUP HEALTH PL/	FECA	OTHER	1a. INSURED'S LD. N	JMBER		Fo	PICA	n 1)
(Medicare #) 🗙 (Medicaid			(Member ID#)	(ID#)	(ID#)	( <i>ID</i> #)	1234567890123					
PATIENT'S NAME (Last Nam OU, JANNIE		diddle Initial)		ATIENTS BIRT MM DD 06 19	NDATE NY 85 M	F X	4. INSURED'S NAME (			ne, Middle	a Initial)	
PATIENT'S ADDRESS (No.,	Street)				IONSHIP TO IN: Child		7. INSURED'S ADDRE	SS (No., S	Street)			
тү			-	elf Spouse ESERVED FOR		Other	СПҮ				STATE	
PCODE	TELEPHONE	(Indude Area	Code)				ZIP CODE		TELEPH	DNE (Indu	ude Area Code)	
OTHER INSURED'S NAME (	Last Name, First	t Name, Middle	e Initial) 10.	IS PATIENT'S	CONDITION REL	ATED TO:	11. INSURED'S POLIC	YGROUP	OR FECA	NUMBER	2	
OTHER INSURED'S POLICY	OR GROUP N	JMBER	a. E	MPLOYMENT?	(Current or Prev	ious)	a. INSURED'S DATE MM 1 DO	OF BIRT	н		SEX	
PL Code if applicab RESERVED FOR NUCCUSI					ES N	-	b. OTHER CLAIMID (			м	F	
			D. A		КЛD	PLACE (State)		-				
RESERVED FOR NUCC US			c. C	Y CONTRACTOR	ES N	。	c. INSURANCE PLAN	NAME OF	ROGRA	M NAME		
NSURANCE PLAN NAME O	R PROGRAM N	IAME	10d	RESERVED F	OR LOCAL USE	-	d. IS THERE ANOTHE	R HEALT	H BENEFIT	PLAN?		
PATIENTS OR AUTHORIZE to process this claim. I also re	BACK OF FOR D PERSON'S S quest payment o	IGNATIONE 4	alpi G I almonize the release	NIG INSI se of any medic self or to the part	DRM and other inform y who accepts as	signment	1 INSU ED FOR A payment of medicar services described	TH RI	D PERSO	V'S SIGN	9, 9a and 9d. ATURE I authoriz hysician or supplie	
below. SIGNED				DATE			SIGNED					
DATE OF CURRENT ILL NE	SS, INJURY, or I QUAL	PREGNANCY	(LMP) 15.OTHE QUAL	R DATE	MM DD	YY	16. DATES PATIENT U MM DD	INABLE T			NT OCCUPATIO	N.
NAME OF REFERRING PR	NUMBER OR OT						FROM			-		
	JVIDER OR OT	HER SOURCE	17a. 71b. NPI	+	i		FROM 18. HOSPITALIZATION MM DD FROM		RELATED		ENT SERVICES	
			71b. NPI		i		18. HOSPITALIZATION MM DD FROM 20. OUTSIDE LAB?	<u> </u>	RELATED T	O CURR		
ADDITIONAL CLAIM INFOR	MATION (Desig	mated by NUC	71b. NPI	line below (24E)	) ICD Ind. 0	1	18. HOSPITALIZATION MM DD FROM 20. OUTSIDE LAB?		RELATED T	O CURR MM O HARGES		
ADDITIONAL CLAIM INFOR	MATION (Desig F ILLNESS OR B.	mated by NUC	C) C) C,	line below (24E)	D. [	1	18. HOSPITAL IZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE	NO	RELATED 1 1 \$ C ORIGINA	O CURR MM O HARGES		
ADDITIONAL CLAIM INFOR	MATION (Desig	mated by NUC	71b. NPI C)	line below (24E	100 1101	1	18. HOSPITALIZATION MM DD FROM 20. OUTSIDE LAB? YES	NO	RELATED 1 1 \$ C ORIGINA	O CURR MM O HARGES		
ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE C 1230011 1	MATION (Desig F ILLNESS OR B F J CE To	mated by NUC	71b. NPI     71b. NPI     C.     G.     C.     C.     L.     D.PROCEDUR	ES, SERVICES		E. DiAGNOSIS POINTER	18. HOSPITAL IZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION CODE	NO	RELATED 1 1 \$ C ORIGINA	I REF. N		6 #
ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE CI 230011 L A. DATE(S) OF SERVI From DD YY MM	MATION (Desig FILLNESS OR B. F. J. D. D. YY 88	INJURY Re		ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS	18. HOSPITALIZATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ F.		RELATED 1 3 C ORIGINA UMBER H. II Branty cu	IL REF. N L REF. N L 23 L 123	0. RENDERING PROVIDER ID 66548 66549875	6
ADDITIONAL CLAIM INFOR DIAGNOSIS OR NATURE C 123 00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	MATION (Desig F ILLNESS OR B. F. J. CE To DD YY SI 10 15	INJURY Re	71b NPI C) alate A-L to service C G D.PROCEDUR (Explain L CPT/A/CPCS T1015	ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS POINTER	18. HOSPITAL CATON FROM 00 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 5. \$ CHARGES 160 00		RELATED 1 3 C ORIGINA UMBER H. I Prenty IL Prenty QU	123 123	0. RENDERING PROVIDER ID 16548 16549875 16548	6
ADDITIONAL QLAM INFOR DIAGNOSIS OR NATURE O IZ300 11 I A. DATE(S) OF SERVI A. DATE(S) OF SERVI DO 10 15 10   0 10 15 10   0 10 15 10	MATION (Desig F ILLNESS OR F J	INJURY RE B C. ACEOF EMOC EMG 11 EPO-ROV	NPI           71b         NPI           C.	ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS POINTER A	18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 7. 5 CHARGES 160 00 0 00			CO CURR TO CURR TO MARGES HARGES L REF. N L REF. N 123 123 123 123 123	0. RENDERING PROVIDER ID 16548 16549875 16548 16549875 16548	3
ADDITIONAL QLAM INFOR Z3 00 11 	MATION (Desig F ILLNESS OR F J	INJURY Re B. C. ACEOF ERMCE EMG 11	71b NPI C) alate A-L to service C G D.PROCEDUR (Epitant, CPT/HCPCS T1015 99213	ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS POINTER	18. HOSPITAL CATON FROM 00 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 5. \$ CHARGES 160 00			CO CURR TO CURR TO MARGES HARGES L REF. N L REF. N 123 123 123 123 123	0. RENDERING PROVIDER ID 16548 16549875 16548 16549875	3 #
ADDITIONAL CLAIM INFOR DAGNOSIS OR NATURE C 	MATION (Desig F ILLNESS OR F J	INJURY R	NPI           71b         NPI           C.	ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS POINTER A	18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 7. 5 CHARGES 160 00 0 00			COCURRING COMMINICO HARGES L REF. NO L REF. NO L 23 PI 123 PI 123 PI 123 PI 123 PI 123	0. RENDERING PROVIDER ID 16548 16549875 16548 16549875 16548	5
ADDITIONAL CLAIM INFOR DAGNOSIS OR NATURE C 	MATION (Desig F ILLNESS OR F J	INJURY R	NPI           71b         NPI           C.	ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS POINTER A	18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 7. 5 CHARGES 160 00 0 00		RELATED 1 S C ORIGINA UMBER Photo Photo Photo Photo Culture Photo Culture Photo Culture Culture Photo Culture	O CURREN O HARGES L REF. N 123 123 123 123 123 123 123 123	0. RENDERING PROVIDER ID 16548 16549875 16548 16549875 16548	5 
ADDITIONAL CLAIM INFOR DAGNOSIS OR NATURE C 	MATION (Desig F ILLNESS OR F J	INJURY R	NPI           71b         NPI           C.	ES, SERVICES	D H OR SUPPLIES tances)	DIAGNOSIS POINTER A	18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 7. 5 CHARGES 160 00 0 00			O CURREN O HARGES L REF. N 123 123 123 123 123 123 123 123 123 123	0. RENDERING PROVIDER ID 16548 16549875 16548 16549875 16548	6
ADDITIONAL QLAM INFOR DIAGNOSIS OR NATURE O 123 00 11 	MATION (Designed to the second	INJURY R B C. ADEOP C. EMOS EMG 11 . EPO-ROV 11 . EN 28	NPI           C)         Idde A-L to service           C. [	ES, SERVICES Inusual Croums MO		DIAGNOSIS POINTER A	18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUMISSION 23. PRIOR AUTHORIZ F. \$ CHARGES 160 00 0 00 0 00 28. TOTAL CHARGE			O CURR O HARGES HARGES L REF. N 123 123 123 123 123 123 123 123 123 123	0. RENDERING PROVIDER ID 16548 16549875 16548 16548 16549875 16548 1	DUE
ADDITIONAL CLAIM INFOR DAGNOSIS OR NATURE C 	MATION (Desig FILLNESS OR B F J CG J CG 10 15 15 10 15	B C. ACEOP ENG 11 ENURY Re 11 ENG ENG ENG ENG ENG 20 11 20 11 20 11 20 21 20 21 20 20 20 20 20 20 20 20 20 20	NP           C)           Glade A-L to service           C. [	ES, SERVICES Insual Crown MO		DIAGNOSIS POINTER A A A A SSIGNMENT? SSIGNMENT?	18. HOSPITAL CATION FROM 20. OUTSIDE LAB? YES 22. RESUBMISSION 23. PRIOR AUTHORIZ 7. S CHARGES 160 00 0 00 0 00 0 00 28. TOTAL CHARGE		RELATED 1	O CURR HARGES 123 123 123 123 123 123 123 123 123 123	0. RENDERING PROVIDER ID 6548 6549875 6548 6548 6549875 6548 6548 6549875 6548 65	

### PAGE(S) 32

09/28/15 04/30/14

### Sample of a Claim Form

MEDICARE MEDICAID TRICARE CHAMPV/		cA (m 1)
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)	
PATIENT'S ADDRESS (No., Street)	KALENDER CONSULT OF CONSULT. CONSULT OF CONSULT. CONSULT OF CONSULT OF CONSULT OF CONSULT. CONSULT OF CONSULT OF CONSULT OF CONSULT. CONSULT OF CONSULTO OF CONSULT. CONSULT OF CONSULT. CONSULTO OF CONSUL. CONSULT. CON	
ITY STATE	Belf Spouse Child Other TE 8. REBERVED FOR NUCC USE CITY STATE	F
10.549		
IP 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	/
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previoue) a. INSURED'S DATE OF BIRTH SEX	P
RESERVED FOR NUCC USE		
RESERVED FOR NUCC USE	C. OTHER ACCIDENT?	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
	YES NO # yes, complete items 9, Ba, and 9d.	
READ BACK OF FORM BEFORE COMPLETING	YES NO # yes, complete items 9, Ba, and 9d.	tza
	YES         NO         # yes, complete items 9, 8a, and 9d.           ING & SIGNING THIS FORM.         13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I sufficiency payment of medical benefits to the undersigned physician or supplier i services described below.	za
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 autorize the to process this claim. I also request payment of government banefite either below. SIGNED 1. CATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.	YES NO # yes, complete theme 9, 8a, and 9d.     YeS OF # yes, complete theme 9, 8a, and 9d.     YeS OF AUTHORIZED PERSON'S BIONATURE I authorize     Payment of modical banefits to the undersigned physician or supplier     aervices described below.     DATE     SIGNED     Is. DATE SIGNED     IS. DATE NMA + DD + YY	tze Herfor
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 automotion the to process this claim. I also request payment of government benefits either below. SIGNED SIGNED A DE CURRENT ILLNESS, INUURY, or PREGNANCY (LMP) TO UNIT DE CURRENT ILLNESS, INUURY, or PREGNANCY (LMP) TO UNIT DE CURRENT ILLNESS, INUURY, or PREGNANCY (LMP) TO UNIT DE CURRENT ILLNESS, INUURY, or PREGNANCY (LMP) TO DE CURRENT CURRENT ILLNESS, INUURY, or PREGNANCY (LMP) CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT CURRENT SIGNED	YES         NO         # yes, complete items 0, 5a, and 9d.           INA & BIONING THE POINT, Invidues of our provide a formation necessary services described balance.         13. INSURED'S OR ALTHORIZED PERSON'S BIONATURE I surfactors payment of medical banefits to the underdyned physician or supplier isoritors described balance.           DATE         SigNED           15. OTHER DATE         MM           DUAL         TO	tze Iller for ON YY
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 autorize the to process this claim. I also request payment of government benefits ditter below. SIGNED	ING & BIONING THIS FORM.     YES     NO     If yes, complete items 8, 8a, and 9d.       ING & BIONING THIS FORM.     13. INSURED'S OR AUTHORIZED PERSON'S BIONATURE I authorize payment of medical bandha to the underdgmed physician or supplier i services described below.       ING & BIONING THE FORM.     13. INSURED'S OR AUTHORIZED PERSON'S BIONATURE I authorize payment of medical bandha to the underdgmed physician or supplier i services described below.       ING DATE     DATE       IS, OTHER DATE     MA       DATE     SIGNED       IS. OTHER DATE     MA       DU     YY       FROM     TO       178.     18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES WITH DO       T78.     TO	tze Iller for ON YY
SIGNED 4. DATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LNP) 15. OLAL QUAL 7. NAME OF REFERING PROVIDER OR OTHER SOURCE 178	INA & BIONING THE POINT.     INFO A SIGNIFIC THE POINT.     INFO A SIGNIFICATION OF THE POIN	tze Iller for ON YY
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 autorize the to process this data. I also request payment of government bandle either bolow. BIGNED	ING & BIONING THIS FORM.     YES     NO     If yes, complete Items 8, 8a, and 9d.       ING & BIONING THIS FORM.     13. INSURED'S OR AUTHORIZED PERSON'S BIONATURE I sufficiency payment of medical bandits to the underdgmed physician or supplier i services described below.       IS. INSURED'S OR AUTHORIZED PERSON'S BIONATURE I sufficiency payment of medical bandits to the underdgmed physician or supplier i services described below.       IS. OTHER DATE     MAR     DD     YV       IS. OTHER DATE     MAR     DD     YV       IS. OTHER DATE     MAR     DD     YV       IS. INSPECTIVE AUTION DATES RELATED TO CURRENT SERVICES WIDD     TO     MM       IT75.     NPI     FROM     TO     MM       20. OUTHIDE LABT     \$ CHARGES       INSPECTIVE INDUCTION DATES RELATED TO CURRENT SERVICES WIDD     YES     NO       avide line below (24E)     ICD Ind.     22. REQUENTION     ORIGINAL REF. NO.	tze Iller for ON YY
READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 autobrose the to process the daim. I also request payment of government benefits either below. BIGNED 4. DATE OF CURRENT ILLNESS, INURY, or PREGNANCY (LMP) 15. I ADTE OF CURRENT ILLNESS, INURY, or PREGNANCY (LMP) 15. I DD QUAL 0. I 0.	ING & BIONING THIS FORM.     YES     NO     If yes, complete Items 8, 8a, and 9d.       ING & BIONING THIS FORM.     13. INSURED'S OR AUTHORIZED PERSON'S BIONATURE I sufficiency payment of medical bandits to the underdgmed physician or supplier i services described below.       IS. INSURED'S OR AUTHORIZED PERSON'S BIONATURE I sufficiency payment of medical bandits to the underdgmed physician or supplier i services described below.       IS. OTHER DATE     MAR     DD     YV       IS. OTHER DATE     MAR     DD     YV       IS. OTHER DATE     MAR     DD     YV       IS. INSPECTIVE AUTION DATES RELATED TO CURRENT SERVICES WIDD     TO     MM       IT75.     NPI     FROM     TO     MM       20. OUTHIDE LABT     \$ CHARGES       INSPECTIVE INDUCTION DATES RELATED TO CURRENT SERVICES WIDD     YES     NO       avide line below (24E)     ICD Ind.     22. REQUENTION     ORIGINAL REF. NO.	tze Iller for ON YY
READ BACK OF FORM BEFORE COMPLETING     PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the is     to process this claim. I also request payment of government bandlits ditter     bots.     SIGNED	INA & BIONING THE PORM.	tze Iller for ON YY
READ BACK OF FORM BEFORE COMPLETING      PATIENT'S OR AUTHORIZED FERSOR'S SIGNATURE 1 compares the compares the persons the compares the persons the compares the persons the compares the persons of government benefits either to boow.      SIGNED      ADATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP)      ADATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP)      ADATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP)      ADATE OF REFERRING PROVIDER OR OTHER SOURCE      ADATE OF SERVICE      ADATE OF SERVI	INITA & RICHNING THER FORM.	Iller for
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the is to process this claim. I also request payment of government benefits either before.  SIGNED  APTE OF CURRENT ILLINESS, INUURY, or PREGNANCY (JMP)  ANTE OF CURRENT ILLINESS, INUURY, or PREGNANCY (JMP)  ANAME OF REFERRING PROVIDER OR OTHER SOURCE  AMME OF REFERRING PROVIDER OF ILLINESS OR INJURY  AMME OF REFERRING  AMME OF REFERRING PROVIDER OF ILLINESS OR INJURY  AMME OF REFERRING  AMME OF	IND. & BIONING THE PORM.	Ider for
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the is to process this claim. I also request payment of government benefits either before.  SIGNED  APTE OF CURRENT ILLINESS, INUURY, or PREGNANCY (JMP)  ANTE OF CURRENT ILLINESS, INUURY, or PREGNANCY (JMP)  ANAME OF REFERRING PROVIDER OR OTHER SOURCE  AMME OF REFERRING PROVIDER OF ILLINESS OR INJURY  AMME OF REFERRING  AMME OF REFERRING PROVIDER OF ILLINESS OR INJURY  AMME OF REFERRING  AMME OF	IND. & SIONING THE POINT.     Image: Solution of the information nonsearcy is included of the information nonsearcy is info	Iller for
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the is to process this claim. I also request payment of government bandlis elitier i botow.  SIGNED INTE OF CURRENT ILLINESS, INJURY, or PREGNANCY (JMP) IS, I DO QUAL INAME OF REFERRING PROVIDER OR OTHER SOURCE ITA ADDITIONAL CLAIM INFORMATION (Designated by NUCC) I. DIAGNOSIS OR NATURE OF ILLINESS OR INJURY Relate A-L to servi E. F. G. L F. G. L L A. DATE(S) OF SERVICE RDM	IND. & BIONING THE PORM.	Iller for
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the is to process this claim. I also request payment of government bandlis elitier i botow.  SIGNED INTE OF CURRENT ILLINESS, INJURY, or PREGNANCY (JMP) IS, I DO QUAL INAME OF REFERRING PROVIDER OR OTHER SOURCE ITA ADDITIONAL CLAIM INFORMATION (Designated by NUCC) I. DIAGNOSIS OR NATURE OF ILLINESS OR INJURY Relate A-L to servi E. F. G. L F. G. L L A. DATE(S) OF SERVICE RDM	IND. & SIONING THE POINT.     Image: Solution of the information nonsearcy is included of the information nonsearcy is info	Iller for
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the is to process this claim. I also request payment of government bandlis elitier i botow.  SIGNED INTE OF CURRENT ILLINESS, INJURY, or PREGNANCY (JMP) IS, I DO QUAL INAME OF REFERRING PROVIDER OR OTHER SOURCE ITA ADDITIONAL CLAIM INFORMATION (Designated by NUCC) I. DIAGNOSIS OR NATURE OF ILLINESS OR INJURY Relate A-L to servi E. F. G. L F. G. L L A. DATE(S) OF SERVICE RDM	IND. & BIOINING THE POPEL.     YES     NO     If yes, complete terms 0, 6a, and 9d.       IND. & BIOINING THE POPEL.     Introduce of the Information necessary inerton myself or to the party who accepts analignment     13. INDURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize pervices described backw.       DATE     IS. INDURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize pervices described backw.       5. OTHER DATE     MAL     DD       YY     IS. OTHER DATE     IS. INSPECTIVE UNABLE TO WORK IN CURRENT OCCUPATION TO       10. DATE     NM     DD       178.     IS. INSPECTIVE UNABLE TO WORK IN CURRENT OCCUPATION TO       179.     IS. OTHER DATE     NM       179.     IS. INSPECTIVE UNABLE TO WORK IN CURRENT OCCUPATION TO       179.     IS. INSPECTIVE UNABLE TO WORK IN CURRENT OCCUPATION TO       179.     IS. INSPECTIVE UNABLE TO WORK IN CURRENT OCCUPATION TO       179.     IS. INSPECTIVE UNABLE TO TO UNABLE TO TO UNABLE TO MM       179.     IS. INSPECTIVE UNABLE TO TO UNABLE TO TO UNABLE TO MM       179.     IS. INSPECTIVE UNABLE TO TO       170.     IS. INSPECTIVE UNABLE TO TO       171.     IS. INSPECTIVE UNABLE TO TO       172.     IS. INSPECT	Iller for
READ BACK OF FORM BEFORE COMPLETING      PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the is     to process this claim. I also request payment of government bandlin elition'     botow.      GIGNED      ADATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP)      ADATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP)      ADATE OF CURRENT ILLINESS, INJURY, or PREGNANCY (LMP)      ADATE OF REFERRING PROVIDER OR OTHER SOURCE      ADATE OF REFERRING PROVIDER OF REFERRING PROVIDER OR OTHER SOURCE      ADATE OF REFERRING PROVIDER OF REFERRING      ADATE OF	IND. & BIOINING THE FORM.     Image: A since of the information necessary intro injustice in an influence of any information necessary intro injustice of any influence of the party with accepta analgorment     13. INCURENCE OR AUTHORIZED PERSONS SIGNATURE I authorize or supplier i services described backwith a constraining of the influence of any influence of the party with accepta analgorment       DATE     13. INCURENCE OR AUTHORIZED PERSONS SIGNATURE I authorize or supplier i services described backwith an influence of the party with accepta analgorment       DATE     SIGNED       Is. OTHER DATE     Mail       DD     YY       Is. OTHER DATE     Mail       DD     YY       Is. OTHER DATE     Mail       DD     YY       Is. RESPIRATED TO CURRENT COCUPATION       FROM     TO       Is. ROSPIT ALIZATION DATES RELATED TO CURRENT COCUPATION       PROM     TO       Is. RESUBMISSION     ORIGINAL REF. NO.       CEDURES, BERVICES, OF BUPPLIES     E.       Is. OTHER     POINTER       SCHARGES     Is. REDERING       IS. OPIOR AUTHORIZATION NUMBER     Is. REDERING       IS. OPIOR AUTHORIZATION NUMBER     Is. REDERING       IS. DISTON     Is. OPIONTER       IS. PRIOR AUTHORIZATION NUMBER     Is. PRIORING       IS. DISTON     Is. OPIONTER       IS. OPIOR AUTHORIZATION NUMBER     Is. PREDERING       IS. OPIOR AUTHORIZAT	Iller for
READ BACK OF FORM BEFORE COMPLETING     PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the      to process this claim. I also request payment of government bandlits elition'     bolow.      GIGNED	IND A SIONING THE PORM.     Image a single provide a single provi	Iller for
READ BACK OF FORM BEFORE COMPLETING     PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I subors the is     to procees the daim. I also request payment of government benefits either below.     SIGNED     (UAL	IND. & BIOINING THE FORM.     Image: A since of the information necessary intro injustice in an influence of any information necessary intro injustice of any influence of the party with accepta analgorment     13. INCURENCE OR AUTHORIZED PERSONS SIGNATURE I authorize or supplier i services described backwith a constraining of the influence of any influence of the party with accepta analgorment       DATE     13. INCURENCE OR AUTHORIZED PERSONS SIGNATURE I authorize or supplier i services described backwith an influence of the party with accepta analgorment       DATE     SIGNED       Is. OTHER DATE     Mail       DD     YY       Is. OTHER DATE     Mail       DD     YY       Is. OTHER DATE     Mail       DD     YY       Is. RESPIRATED TO CURRENT COCUPATION       FROM     TO       Is. ROSPIT ALIZATION DATES RELATED TO CURRENT COCUPATION       PROM     TO       Is. RESUBMISSION     ORIGINAL REF. NO.       CEDURES, BERVICES, OF BUPPLIES     E.       Is. OTHER     POINTER       SCHARGES     Is. REDERING       IS. OPIOR AUTHORIZATION NUMBER     Is. REDERING       IS. OPIOR AUTHORIZATION NUMBER     Is. REDERING       IS. DISTON     Is. OPIONTER       IS. PRIOR AUTHORIZATION NUMBER     Is. PRIORING       IS. DISTON     Is. OPIONTER       IS. OPIOR AUTHORIZATION NUMBER     Is. PREDERING       IS. OPIOR AUTHORIZAT	In the second se

#### 09/28/15 04/30/14

### 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 – not adjusted or voided.

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

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

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

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

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

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

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

#### Adjustments/Voids Appearing on the Remittance Advice

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

### 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.

Samples are on the following pages.

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

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

EALTH INSURANCE CLAIM FORM ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA		PICA
MEDICARE MEDICAID TRICARE CHAMPV/ (Medicare #) X (Medicaid #) (ID#DoD#) (Member II	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY	1234567890123 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OU, JANNIE	06 19 85 M F X	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
TY STATE	8. RESERVED FOR NUCC USE	CITY STATE
P 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
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
PL Code if applicable RESERVED FOR NUCC USE	VES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	<b>SAANDI E</b>	,
RESERVED FOR NUCC USE	a OTHERACODENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE	A IS THERE ANOTHER HEALTH BENEFIT PLAN?
EXA	AMPLE OF I	NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either t	release of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
below. SIGNED	DATE	SIGNED
MM DD YY	THER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
QUAL. QUA. QUA. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		FROM TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	NPI	FROM TO TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to se	rvice line below (24E) ICD Ind 9	22. RESUBMISSION CODE ORIGINAL REF. NO.
. V2501 B. C. L	D. [	A 99 4090145678600
E F G	н.	23. PRIOR AUTHORIZATION NUMBER
J. K. K. J. K. J. K. J. K. J. PROCE	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J. DAYS EPSOT ID PENDERAIG
From To PLACE OF (Exp M DD YY MM DD YY SERVICE EMG CPT/HCP	lain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	\$ CHARGES UNITS Plan QUAL. PROVIDER ID. #
3 02 14 03 02 14 11 T101	5 A	1236548 150 00 1 NPI 1236549875
		· · · · · · · · · · · · · · · · · · ·
		NPI
		NPI
		NPI
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	X YES NO	\$ 150 00 \$ \$
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open RHC/FQHC 123 Main St Arvi Taring LA 20000
		Any Town, LA 70000 a. 1326547895 b. 1234567
GNED Jane Doe, MD DATE 3/9/14 a.	b. PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02

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

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

09/28/15

04/30/14

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

R FED ALTH INSURANCE CLAIM FORM ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			
PICA			PICA
MEDICARE MEDICAID TRICARE CHAMPVA (Medicare #) 🗙 (Medicaid #) (ID#/DoD#) (Member ID	HEALTH PLAN BLK LUNG (ID#) (ID#) (ID#)	1a. INSURED'S LD. NUMBER 1234567890123	(For Program in Item 1)
A TIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	4. INSURED'S NAME (Last Name,	First Name, Middle Initial)
DU, JANNIE ATIENT'S ADDRESS (No., Street)	06 19 85 M F X 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Str	nel)
	Self Spouse Child Other		,
Y STATE	8. RESERVED FOR NUCC USE	CITY	STATE
CODE TELEPHONE (Indude Area Code)		ZIP CODE 1	TELEPHONE (Include Area Code)
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP (	C )
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
PL Code if applicable ESERVED FOR NUCCUSE	YES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIMID (Designated b	M F
ESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR F	ROGRAM NAME
ISURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH	BENEFIT PLAN?
			es, complete items 9, 9a and 9d.
READ BACK OF FORM B FORF A W ATTENT'S OR AUTHORIZED PERSON'S SIGN FORE TO AUTHORIZED TO	8 GLIN THIS FOR L revuse of any measured or other information medeaser.	payment of measure benefits to I	PERSON'S SIGNATURE I authorize the undersigned physician or supplier for
o process this claim. I also request payment of government benefits either t elow.	o myself or to the party who accepts assignment	services described below.	
SIGNED	DATE	SIGNED	
QUAL QUAL QUAL	THER DATE MM DD YY	FROM	WORK IN CURRENT OCCUPATION MM DD YY TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a		18. HOSPITALIZATION DATES RE	
71b.	NPI	FROM	то
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO	\$ CHARGES
	vice line below (24E) ICD Ind. 0	22. RESUBMISSION	ORIGINAL REF. NO.
Z30011 B. C. L	D.		299198798700
F. G.	н	23. PRIOR AUTHORIZATION NUN	IBER
JK A. DATE(S) OF SERVICE B. C. D.PROCE	DURES, SERVICES, OR SUPPLIES E.	F. G. DAYS E	H. L J.
From To PLACEOF (Exp DD YY MM DD YY SERVICE EMG CPT/HCP	lain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	\$ CHARGES UNITS	PROT ID. RENDERING anity Plan QUAL. PROVIDER ID. #
10 15 10 10 15 11 T101	5       A	160 00	1236548 NPI 1236549875
			NPI
			NPI
			NPI
			NPI
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	CCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. /	MOUNT PAID 30. BALANCE DUE
1234	(For govt. daime, see back) X YES NO	s 160 00 s	s 160 0
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FA	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & I ALWAYS OPEN RHC/	(,
NCLUDING DEGREES OF CREDENTIALS [ certify that the statements on the reverse apply to this bill and are made a part thereof.)		123 MAIN ST	1
certify that the statements on the reverse	b.	123 MAIN ST ANY TOWN, LA 70000 a. 1326547895 b	1234567

### 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

09/28/15 04/30/14

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

### **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> (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)	Optional – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20	
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.	

## REPLA

### 09/28/15 04/30/14

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

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. If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator in Block 25.	Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
28	Tooth Surface	Situational – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: 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	Required Enter the dentist's full (usual and customary) fee for the dental procedure reported.			
32	Other Fee(s)	Leave Blank			
33	Total Fee	Required – Total of all fees listed on the claim form.			
34	(Place an 'X' on each missing tooth)	Situational – Complete if applicable.         Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".         ace an 'X' on each       In the following circumstances, this information is required:			

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	Disco of Transmont	<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).	<b>Situational</b> . If Block 45 is completed, then this block is <b>required</b> . 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	ption Instructions						
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

09/28/15

04/30/14

### Sample of ADA Claim Form

ADIA. Dental Claim Form	MSA 07-02			
HEADER INFORMATION	Attachment 1			
1. Type of Transaction (Mark all applicable boxes)				
Statement of Actual Services Prequest for Predetermination/Preauthorization				
EPSDT/TRe XIX     Predetermination/Presutholization Number				
123456789	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffic), Address, City, State, Zp Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION				
3. Company/Flan Name, Address, City, Stale, Zp Code	Brown, Wade			
	8269 Chilly Rd			
	Winter, LA 70000			
	13. Date of Birth (MMDD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)			
	08/14/2004 🛛 🖄 🗆 1234567890123			
OTHER COVERAGE	16. Plan/Group Number 17. Employer Name			
4. Other Dental or Medical Coverage? XNo (Skip 5-11) Ves (Complete 5-11)				
5. Name of Policyholdes/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION 18. Relationship to Policyholder/Subscriber in #12 Above 19. Studient Status			
6. Date of Birth (MMCD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	18. Relationship to PolicyholderSubscriber in #12 Above  19. Student Status  19. Stud			
	20. Name (Last, Fint, Middle Initial, Suffix), Address, City, State, Zp Code			
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5	and the second start and a second start of the second start of the second			
TPL Carrier Code Set Spruse Dependent Coner				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zp Code	1 1			
	21. Date of Birth (MMDD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)			
	□ M □ F			
RECORD OF SERVICES PROVIDED				
24. Procedure Date (MMDD/CC/Y) 25. Area 25. 27. Tooth Number(s) 28. Tooth 29. Proce (MMDD/CC/Y) System of L45er(s) Surface Code	Store 30. Description S1. Fee			
	99 Encounter - All Inclusive 100 00			
2 1/14/12 10 D434	99 Encounter - All Inclusive 100 00 41 Periodontal Scaling and Root Planing 110 00			
1/14/12 13 D29	54 Post & Core 94:00			
4 1/14/12 15 D29	31 Stainless Steel Crown 140 00			
5				
0				
7				
V				
MISSING TEETH INFORMATION Permanent	Pimary 32. Other			
	13 14 15 16 A B C D E F G H I J F4400			
34. (Place an X on each missing room) 32 31 30 29 28 27 26 25 24 23 22 21	20 19 18 17 T S R Q P O N M L K 33.Total Fee 444 00			
35 Remarks IF TPL involved: write the words "Carrier P	aid" and enter the amount paid by the TPL here.			
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION 38. Place of Teatment 39. Number of Enclosures (00 to 99)			
35. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the topoletic dental is excluded any prohibited by any other and the service and materials more than a content of the service and materials and the service and the servic	28. Place of Treatment     29. Number of Encircules (00.19.09)     10.001ni			
charges for detail services and materials for paid by this dential benefit pain, unless prohibited by law, or the treating dential control to dental practice has a control and approximate with my pain prohibiting all or a portion or such charges. To the extent permitted by law, I consent to your use and disclosure of my protected heatth altermation to carry our payment activities in consent to your use and disclosure of my protected heatth altermation to carry our payment activities in consent to your use and disclosure of my protected heatth altermation to carry our payment activities in consent to your use and disclosure of my protected heatth altermation to carry our payment activities in consent to your use and disclosure of my protected heatth altermation to carry our payment activities in the second payment of the payment of the second payment of the seco	4). Is Treatment for Orthodoxtics? 41. Date Applance Placed (MMDDCCCYY)			
anormation to carry our payment accretion in connection with this carry.	No (5kp 41-42) Yes (Complete 41-42)			
X Patent/Guardian signature Date	42. Months of Treatment Permaning 42. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)			
	Pemaining Viss (Complete 44)			
37. I hereby sufforize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	45. Treatment Resulting from			
x	Cccupational illness/injury Auto accident Other accident			
Subscriber signature Date	45. Date of Accident (MM/DD/CCYY) 47. Auto Accident State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting	TREATING DENTIST AND TREATMENT LOCATION INFORMATION			
claim on behalf of the patient or insured/subscriber)	53. Thereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.			
48. Name, Address, City, State, 2p Code XYZ Dental Group	Dr Mary Cleanteeth 3/14/12			
	X Signed (Treating Dentist) Date			
8956 No Cavity Ave.	54. NPI1234567890 55. License Number 999999			
Smiley, LA 700000	56. Address, City, State, Zip Code SSA. Provider Security Code			
49. NP1 50. Ucense Number 51. SSN or TIN	opecasy core			
1987654321				
32 Floore (222)999-4444 StA Additional 1234567	57. Phone ( ) - 58. Additional Provider ID 1987654			
© 2006 American Dental Association J400 (Jame as ADA Dental Claim Form – J401, J402, J403, J404)	To Receder call 1-800-547-4746 or go online at www.adacatalog.org			

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

Page 25 of 32

09/28/15 04/30/14

### 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	<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>	
8	Sex	<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>	
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	<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>	

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/Ac Numbe				
NOR PREAUTHORIZATION MAIL TO: LU SCHOOL OF DENTISTRY MIDICUD DENTIL PROGRAM TIOR CORES, AVE., DOX 510 NEW CREAKE, LA 30119	FOR PAYMENT BEMIT TO: Molina Medica P.O. BOX 91022 BATON ROUGE, U (300) 473-2783 (225) 924-5040			ARTMENT BUREAU OF MEDICA PR	TE OF LOUIS OF HEALTH AN HEALTH SERVICE AL ASSISTANCE PI OVIDER BILLING I SDT DENTAL SERV	ND HOSPIT S FINANCING ROGRAM FOR	TALS	S	AN	<b>I</b> P	LE	Ξ
								FOR OFFIC	E USE ONLY			
PATENTS LAST NAME (RENT)			10.00			/	<b>1</b>		ASSISTANCE LD. NA			
Smith PATIENT'S ADDRESS (STREET HUR	BER, CITY, MARE, 31P C	000 (TS. NO.)	5	ally	/			1 2 7 EATE OF		6789	9 0 1	2 3
F									2 15	2002	_ m 🔀	C F
BRITERING AGENCY NO.	DO DATE O	OF REFERENCE		EMER	SENC SCIEDNING	NAME	HOUP REFERED 1	0				
ET REFERENCE ET (SICHARURE)	14 12.0%	ONE NO.	-		SCREENING ON A KINGHO IF DIVID			_				_
						TEL NO		_				_
AVID DENISTOR GROUP					1800000	GROUP PROVIDER	INO.		NO INC			
NAME					REALMENT NO.250		T YES	PATINENI In Call	OF X4ANS	The sec		-
ADDRESS					A. EMPLOY		□ NO	1				
CITY	ST		DP		B. ACCIDEN	IT/INUURY	□ YES □ NO					_
P ROSHESS, 5 145 THE INITIAL PLACEMENT?	YES BE	IF ADULT EN	RGENC	Y SERVICE,	DENTAL PROGRAM			3				_
					AENT PLAN - UST I		M TOOTH N		0.32-USEO6	ARTING SYSTEM	SHOWN	-
2		100RH	B.	c		D.			L DATE SERVICE	ADAUSTED PER	G.	
TACIAL CODO	Dr.	#OR S	EAR	ROCEDURE CODE	DESCR	PTION OF SERVIC	CE.	UNIS M	PERFORMED IO. DAY YR.	(FOR STATE USE CHEY)	USUAL A CUEIOMA	IND RY FEE
\$ 2000		16		D2931	Stainless	Steel C	rown	0	2 16 12		135	00
	8.8		H.	er.	01				TAXA CHI	E BY	s	
BIGHT	1		_						EX DATE OF	ENERTIANCE ADVICE D	sal .	5
Come of the second	ALANENT C			65400		HILL IS NOT	COMPLET CONS AN THE REWITTA GUMED (	VOENG A TAE KOL NUMBER A NGL ADVICE I	03/10	6/2012		
	- 8"0	REASO	IS FOR	ADJUSTMEN	π							
Carden of	89.89 8									#: should	d	_
ONER:	200		01 TR	IRD PARTY U	ABUTY RECOVERY	,	be	tooth a	#16, not 1	5.		
FACIAL	Or .		02 PI	IOVIDER CO	RECTIONS							
A. INK IN RESTORA				SCAL AGENT	ERROR USE ONLY - RECO	VERY						
<ol> <li>INDICATE MISSIN WITH AN-X.</li> </ol>	NG TEETH			THER - PLEAS		1241	_					
C. INDICATE CROW	INS WITH											
D. INDICATE TEETH	TO BE											
EXTRACTED WIT		29 REASO	NS FOR	VOID								
REMARKS FOR UNLIGHT	A SERVICE	10					_				_	
					R WRONG RECIPIE		_					
		ШН		AIM PAID TO HER - PLEASE	WRONG PROVIDE	ER.	_					
				- In The Hall			_					
							_					
							_					
			Data of the	0.00.000	CONTROL DUILD	0000	Ballet Hard					
I HAVE READ THE CERTIFIC			CREM AN	11 REQUEST FOR	NE AUTORZATION IN	OR STATE USE ON	24		Dr. Gor :	Smiley, DD:	s	_
ATTEND	NG DENTSPS SIGNATU	RE .	-		OVED - YES		V/EXCEPTION	5 🗌		TRACE CONTRACTS	SOM OF	_
				PA	123456780			DAT	188888	NOVERTIL	1/05/201	2
RONDER NUMBER			64AE	AUHOREE	- serviced			JA1				
											MO	10/04

### **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	<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>	
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.	

Description

Payment Source Other

Than Title XIX

Locator #

20

21 22

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

	5	
	Not required,	
	Leave blank,	
	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,	
ble by Other	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	

Instructions

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.

22		Leave Dialik,	
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	<ul> <li>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).</li> <li>Void - Enter the information exactly as it appeared on the original invoice,</li> </ul>	
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.

**PAGE(S) 32** 

Alerts

#### 09/28/15 04/30/14

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

### PAGE(S) 32

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

					Pa	tient ID/Acco Number	unt		
COR PREAUTHORIZATION MA, TO 30 SOND, OF DUTITITIN ROMANNEL ME, BOX TO BH (RELING, UL 7011) CALL ADJ VOID	aid Solutions				SAMPLE				
PATIENT'S LAST NAME (PRINT)	<b>2</b> A	RSTNAME				MEDICAL ASSIST		1000	
Que	Su		/		L			9 0 1 2 3	
PATIENTS ADDRESS (STREET NUMBER, C	TY, STATE, 2P CODE) (TEL	NO.)	/			06 19 19			
REFERRING AGENCY NO. 10	DATE OF REFERMAL		-/	12 DENTIST OR	SHOLP HEP		55		
			/	NAME	_				
REFERRED BY: (SIGNATURE)	TELEPHONE NO.	ACESC	ACCOUNT # HEREINED ID	TEL NO					
PAY TO DENTIST OR GROUP			17 PAY TO DENTI	ST OR GROUP PROVID	NER NO.	ARE X-RAYS ENG	LOSED?		
NAME			1800000			YES NUMBER OF X-RA	ON		
ADDRESS		_	TREATMENT N	ECESSITATED BY:	200303	PAYMENT SOURCE	E OTHER THAN TITLE	XX	
	7. 79		A. EMPLOYM		] YES ] NO	1			
# PROSTHESIS, IS THIS	1 DF		-	contractor 🛛 🖡	J NO	2			
THE INITIAL PLACEMENT?	YES 1	NO	B. ACCIDENT	UNAUNT -	NO	3			
	A PROCEDURE	8.	DESCRIPTIO	N OF SERVICE		C. DATE SERVICE PERFORMED	D. ADJUSTED FEE (40) STATUSE OILS	L USUAL AND CUSTOMARY FEE	
INCOM.	D0999	Encou	nter All Inci	usive		01 20 12	1	125 0	
- COURT OF COURT	F. ORAL CAVITY	-		G. 100	DH #		PAID OR PAYABLE BY OTHER CARRIER	s	
¢ R	(1) IS THE PATIEN						OTHER CARRIER	1 i.	
	COMMENTS:	NO	YES 🗆 F	ULL 🗌 PARTIA		MO			
	(2) NAME AND	ADDRESS	YEAR WAS YOUR OF DENTIST	LAST DENTURE M		UPPER	LOWER		
INDICATE TEETH TO BE EXTRACTED WITH A/.	(3) HAVE YOU	EVER RECK	EIVED A DENTURI	E UNDER THE MEDI	CAID PRO	GPAM7	YES	NOL	
INDICATE MISSING TEETH WITH AN X.	2131198765			THES IS FOR CHANG ITEM, THE CONNECT SHOWN ON THE R ALMAYS RECOVERD	T CONTROL N EMITTANCE	A MARTIN AD	5/18/12	ovići Ifalo	
	REASONS FOR				Billed	wrong cha	rge amount.		
SKETCH IN DESIGN OF	01 THRD PARTY LIABILITY RECOVERY				Initial	itially billed \$12.50 instead of			
PARTIAL DENTURE TO BE CONSTRUCTED						125.00			
INDICATING TEETH TO BE REPLACED AND	90 STATE OFFICE USE ONLY - RECOVERY								
TEETH TO BE CLASPED.	99 OTH	ER - PLEAS	EDPLAN						
	REASONS FOR	QIOV F							
	10 CLAIM PAID FOR WHONG RECIPIENT								
	11 CLAM PAD TO WRONG PROVIDER 99 OTHER - PLEASE EXPLAIN								
		ER PLENS	ELAPONIN		_				
I HAVE READ THE CERTIFICATION ON THE	REVERSE OF THIS FORM A	NO DO HEREB	Y CERTIFY THAT IA	MIN COMPLIANCE TH	EREWITH.				
REQUEST FOR AUTHORIZATION - BEND TO O		IT REQUEST	FOR AUTHORIZATION	FOR STATE USE ONLY)	Sec. and		a for care	200	
		APPROV	ED YES	NO WIE	XCEPTIO		ATTENDING DENT	ET'S SCRATORE	
ATTENONG DENTIST'S SK	Seat Land					14	888888	05/20/12	
PROVIDEN NUMBER	DATE					-	PROVIDER	NUMBER	
								MOLINA	