

CLAIMS FILING

Hard copy billing of waiver 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:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

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

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

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APPENDIX E – CLAIMS FILING

This appendix includes the following:

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

CMS 1500 (02/12) INSTRUCTIONS FOR SUPPORTS WAIVER SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's ID Number	Required – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS, or REVS. NOTE: The beneficiary's 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial.	

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Locator #	Description	Instructions	Alerts
3	Patient's Birth Date Sex	Situational – Enter the beneficiary's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the beneficiary's permanent address.	
6	Patient's 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		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If beneficiary 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. The 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.

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Locator #	Description	Instructions	Alerts
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient’s Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured’s Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured’s Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient’s or Authorized Person’s Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured’s or Authorized Person’s Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	

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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.	
17a	Unlabeled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

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Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).</p>
22	Resubmission Code	<p>Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery</p>	<p>Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</p>

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Locator #	Description	Instructions	Alerts
		02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	
23	Prior Authorization Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational	
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	Required -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required -- Enter usual and customary charges for the service rendered.	

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Locator #	Description	Instructions	Alerts
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID#	Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is optional .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax ID Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter ‘0’ if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	RESERVED FOR NUCC USE	Leave Blank.	

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Locator #	Description	Instructions	Alerts
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number must appear on paper claims.

REMINDER: MAKE SURE “WAIVER” IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

**Sample forms are on the following pages
 SAMPLE WAIVER CLAIM FORM WITH ICD-10 DIAGNOSIS CODE
 (DATES BEFORE 10/01/15)**

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APPENDIX E – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#, DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#)										1a. INSURED'S I.D. NUMBER 9876543210123				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS					3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 M X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO c. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC)							
12. PATIENTS OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 15. OTHER DATE QUAL MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 71b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES NO \$ CHARGES							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (2-4E) ICD Int 0 A. G5 10 B. C. D. E. F. G. H. I. J. K. L.		22. SUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER Prior Auth#							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAY'S OR UNITS H. (P/S) Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#														
1 10 08 15 10 08 15 12 S5125 UN A 90 00 30 NPI														
2 10 09 15 10 09 15 12 S5125 UN A 75 00 25 NPI														
3 NPI														
4 NPI														
5 NPI														
6 NPI														
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENTS ACCOUNT NO. 1234		27. ACCEPT ASSIGNMENT? (For gen. claim, see back) X YES NO		28. TOTAL CHARGE \$ 165 00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 165 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)					32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000							
SIGNED Ima Biller DATE 10/15/15					a. 123967654		b. 1239876							

EXAMPLE OF ICD 10

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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

ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

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

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; or
- 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 Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

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

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

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Sample forms are on the following pages.

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APPENDIX E – CLAIMS FILING



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()				
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____					15. OTHER DATE MM DD YY QUAL _____		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					23. PRIOR AUTHORIZATION NUMBER _____						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. REPORT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI		
2									NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER		SBN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Paid for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____		33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____				

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION