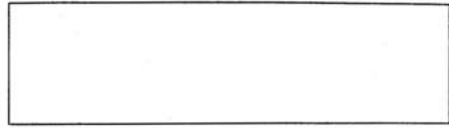


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 924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
 BUREAU OF HEALTH SERVICE FINANCING
 MEDICAL ASSISTANCE PROGRAM
 PROVIDER BILLING FOR
 HEALTH INSURANCE CLAIM FORM



FOR OFFICE USE ONLY

1 ADJ. VOID

| | | | |
|---|--|---|--|
| PATIENT AND INSURED (SUBSCRIBER) INFORMATION | | | |
| 2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) | | 3 PATIENT'S DATE OF BIRTH | |
| 5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) | | 6 PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> | |
| TELEPHONE NO. _____ | | 8 PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> | |
| 10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER. | | 11 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | | 14 DATE FIRST CONSULTED YOU FOR THIS CONDITION | |
| 16 DATE PATIENT ABLE TO RETURN TO WORK | | 17 DATES OF TOTAL DISABILITY FROM _____ THROUGH _____ | |
| 18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | 18A REFERRING ID NUMBER | |
| 20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) | | 15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE. | | 19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____ | |
| 1 _____ 2 _____ 3 _____ | | 21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____ | |
| 25 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | 23 ATTENDING NUMBER _____ | |
| B. PLACE OF SERVICE _____ | | 24 PRIOR AUTHORIZATION NO. _____ | |
| C. PROCEDURE _____ | | D. DIAGNOSIS CODE _____ | |
| E. CHARGES _____ | | F. DAYS OR UNITS _____ | |
| G. EPSDT FAMILY PLAN _____ | | H. TPL \$ _____ | |

26 CONTROL NUMBER THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.) **27** DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

01 THIRD PARTY LIABILITY RECOVERY _____

02 PROVIDER CORRECTIONS _____

03 FISCAL AGENT ERROR _____

90 STATE OFFICE USE ONLY - RECOVERY _____

99 OTHER - PLEASE EXPLAIN _____

29 REASONS FOR VOID

10 CLAIM PAID FOR WRONG RECIPIENT _____

11 CLAIM PAID TO WRONG PROVIDER _____

99 OTHER - PLEASE EXPLAIN _____

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
 (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.) _____

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE _____

32 YOUR PATIENT'S ACCOUNT NUMBER _____

INSTRUCTIONS FOR FILING MOLINA 213 ADJUSTMENT/VOID CLAIMS

- *1. **REQUIRED ADJ/VOID**—Check the appropriate block
- *2. **REQUIRED Patient's Name**
 - a. **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information
 - b. **Void**—Print the name exactly as it appears on the original claim
3. **Patient's Date of Birth**
 - a. **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information
 - b. **Void**—Print the name exactly as it appears on the original claim
- *4. **REQUIRED Medicaid ID Number**—Enter the 13 digit recipient ID number
5. **Patient's Address and Telephone Number**
 - a. **Adjust**—Print the address exactly as it appears on the original claim
 - b. **Void**—Print the address exactly as it appears on the original claim
6. **Patient's Sex**
 - a. **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information
 - b. **Void**—Print this information exactly as it appears on the original claim
7. **Insured's Name**— Leave blank
8. **Patient's Relationship to Insured**—Leave blank
9. **Insured's Group No.**—Complete if appropriate or blank
10. **Other Health Insurance Coverage**—Complete with 6-digit TPL carrier code if appropriate or leave blank
11. **Was Condition Related to**—Leave blank
12. **Insured's Address**—Leave blank
13. **Date of**—Leave blank
14. **Date First Consulted You for This Condition**—Leave blank
15. **Has Patient Ever had Same or Similar Symptoms**—Leave blank
16. **Date Patient Able to Return to Work**—Leave blank
17. **Dates of Total Disability-Dates of Partial Disability**—Leave blank

18. **Name of Referring Physician or Other Source**—Leave this space blank
- 18a. **Referring ID Number**—Enter The CommunityCARE authorization number if applicable or leave blank.
19. **For Services Related to Hospitalization Give Hospitalization Dates**—Leave blank
20. **Name and Address of Facility Where Services Rendered (if other than home or office)**—Leave blank
21. **Was Laboratory Work Performed Outside of Office**—Leave blank
- *22. **REQUIRED Diagnosis of Nature of Illness**
 - a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information
 - b. **Void**—Print the information exactly as it appears on the original claim
23. **Attending Number**—Enter the attending number submitted on original claim, if any, or leave this space blank
24. **Prior Authorization #**—Enter the PA number if applicable or leave blank
- *25. **REQUIRED A through F**
 - a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information
 - b. **Void**—Print the information exactly as it appears on the original claim
- *26. **REQUIRED Control Number**—Print the correct Control Number as shown on the Remittance Advice
- *27. **REQUIRED Date of Remittance Advice that Listed Claim was Paid**—Enter MM DD YY from RA form
- *28. **REQUIRED Reasons for Adjustment**—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary
- *29. **REQUIRED Reasons for Void**—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary
- *30. **REQUIRED Signature of Physician or Supplier**—All Adjustment/Void forms **must** be signed
- *31. **REQUIRED Physician's or Supplier's Name, Address, Zip Code and Telephone Number**—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. ***The form will be returned if this information is not entered.***
32. **Patient's Account Number**—Enter the patient's provider-assigned account number.

Marked (*) items must be completed or form will be returned.