

CLAIMS FILING

Hard copy billing of Durable Medical Equipment (DME) 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

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

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and
2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

CMS-1500 (02/12) INSTRUCTIONS FOR DME SERVICES

Please click the following link to access “CMS-1500 (02/12) Instructions for DME Services”:
https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500_DME.pdf.

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 (RA), 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:

1. 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; and
2. 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 (ID) Number and the Beneficiary/Patient ID 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 RA 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 RA.

Sample forms are on the following pages

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

SAMPLE DME CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES OF SERVICE ON OR AFTER 10/01/15)



HEALTH INSURANCE CLAIM FORM

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

DME

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

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> RESOLD HEALTH PLAN <input type="checkbox"/> FECA/BLK/CLUNG <input type="checkbox"/> OTHER											
1. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE						2. PATIENT'S BIRTH DATE 06 11 00 SEX: M <input type="checkbox"/> F <input checked="" type="checkbox"/>					
3. PATIENT'S ADDRESS (No., Street) CITY: _____ STATE: _____						4. INSURED'S NAME (Last Name, First Name, Middle Initial) CITY: _____ STATE: _____					
5. PATIENT'S ADDRESS (No., Street) CITY: _____ STATE: _____						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
7. PATIENT'S POLICY OR GROUP NUMBER TPL CODE IF APPLICABLE						8. EMPLOYMENT? (Current or Previous) a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO					
10. IS PATIENT'S CONDITION RELATED TO: a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER					
11. INSURED'S POLICY GROUP OR FECA NUMBER						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 appropriate credit assignment below.) SIGNED: _____ DATE: _____					
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 appropriate credit 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 determined to be reasonable and necessary.) SIGNED: _____ DATE: _____					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (CMP) MM DD YY QUAL: _____						15. OTHER DATE MM DD YY QUAL: _____					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JOHN DOE, MD						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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (24E) A: G809 E: Z931 C: _____ D: _____ I: _____ J: _____ K: _____ L: _____						22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO: 6259012345600					
24. A. DATE(S) OF SERVICE From: MM DD YY To: MM DD YY						24. B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) C. ICD-10 CODES (Designated by NUCC) D. MODIFIER					
1. 09 08 16 09 08 16 12 A4322 AB 90.00 30 NPI						2. _____ _____ _____ _____ _____ NPI					
3. _____ _____ _____ _____ _____ NPI						4. _____ _____ _____ _____ _____ NPI					
5. _____ _____ _____ _____ _____ NPI						6. _____ _____ _____ _____ _____ NPI					
25. FEDERAL TAX I.D. NUMBER SSN/EIN						26. PATIENT'S ACCOUNT NO: 1234					
27. ACCEPT ASSIGNMENT? (For prior claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE: \$ 90.00 29. AMOUNT PAID: \$ _____					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (Certify that the statements on the reverse apply to this bill and are made a part thereof) IMA BILLER SIGNED: _____ DATE: 9/12/16						32. SERVICE FACILITY/LOCATION INFORMATION a. NPI b. _____					
33. BILLING PROVIDER INFO & PH# (800) 233-3333 XYZ DURABLE MEDICAL SERVICES 700 MAIN ST ANY TOWN, LA 70000						34. 1326547895 35. 1987654					

SAMPLE
EXAMPLE OF ICD 10
WITH A REFERRING PROVIDER

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

Sample of a Claim Form



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																																																																																																																																																																											
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)				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)				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				8. RESERVED FOR NUCC USE				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:																																																																																																																																																																			
10a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				10b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				10c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																																																																																			
10d. CLAIM CODES (Designated by NUCC)				11. INSURED'S POLICY GROUP OR FECA NUMBER				11a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)																																																																																																																																																																			
11b. OTHER CLAIM ID (Designated by NUCC)				11c. INSURANCE PLAN NAME OR PROGRAM NAME				11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.																																																																																																																																																																			
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 _____ DATE _____						SIGNED _____																																																																																																																																																																					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL.				15. OTHER DATE (MM DD YY) QUAL.				16. 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																																																																																																																																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Incl.																																																																																																																																																																											
22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																											
23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																											
<table border="1"> <thead> <tr> <th>24. A.</th> <th>DATE(S) OF SERVICE</th> <th>B.</th> <th>PLACE OF SERVICE</th> <th>C.</th> <th>EMG</th> <th>D.</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>E.</th> <th>DIAGNOSIS POINTER</th> <th>F.</th> <th>§ CHARGES</th> <th>G.</th> <th>DAYS ON UNITS</th> <th>H.</th> <th>EPST/Plan</th> <th>I.</th> <th>ID. QUAL.</th> <th>J.</th> <th>RENDERING PROVIDER ID. #</th> </tr> <tr> <th>MM DD YY</th> <th>From To MM DD YY</th> <th>MM DD YY</th> <th>MM DD YY</th> <th></th> <th></th> <th>CPT/HCPCS</th> <th>MODIFIER</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> </tbody> </table>												24. A.	DATE(S) OF SERVICE	B.	PLACE OF SERVICE	C.	EMG	D.	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E.	DIAGNOSIS POINTER	F.	§ CHARGES	G.	DAYS ON UNITS	H.	EPST/Plan	I.	ID. QUAL.	J.	RENDERING PROVIDER ID. #	MM DD YY	From To MM DD YY	MM DD YY	MM DD YY			CPT/HCPCS	MODIFIER													1																			NPI	2																			NPI	3																			NPI	4																			NPI	5																			NPI	6																			NPI
24. A.	DATE(S) OF SERVICE	B.	PLACE OF SERVICE	C.	EMG	D.	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E.	DIAGNOSIS POINTER	F.	§ CHARGES	G.	DAYS ON UNITS	H.	EPST/Plan	I.	ID. QUAL.	J.	RENDERING PROVIDER ID. #																																																																																																																																																								
MM DD YY	From To MM DD YY	MM DD YY	MM DD YY			CPT/HCPCS	MODIFIER																																																																																																																																																																				
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. Rvd 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				33. BILLING PROVIDER INFO & PH # ()																																																																																																																																																																			
a. NPI b.				a. NPI b.																																																																																																																																																																							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)