**CHAPTER 30: PERSONAL CARE SERVICES** 

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#### CLAIMS RELATED INFORMATION

Hard copy billing of Personal Care Services (PCS) are billed on the CMS-1500 (02/12) claim form or electronically in the 837P 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 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 <a href="www.lamedicaid.com">www.lamedicaid.com</a>, 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

Appendix H

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• Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

#### CMS 1500 (02/12) Billing Instructions for Personal Care 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 #).	
1a	Insured's I.D. Number	Required – Enter the recipient/beneficiary's 13-digit Medicaid I.D. number exactly as it appears when checking recipient/beneficiary eligibility through MEVS, eMEVS, or REVS.  NOTE: The recipient/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 recipient/beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the recipient/beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date  Sex	Required – Enter the recipient/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 recipient/beneficiary.	

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Locator #	Description	Instructions	Alerts
4	Insured's Name	Situational – Complete correctly if the recipient/beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient/beneficiary's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	Leave Blank.	
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Leave Blank.	
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	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	

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Locator #	Description	Instructions	Alerts
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – 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.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Leave Blank.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable. Enter the applicable qualifier to the left of the vertical, dotted line to Identify which provider is being reported.  • DK Ordering Provider  In the following circumstances, entering the name (First Name, Middle Initial, Last Name) followed by the credentials of the ordering physician or non-physician practitioner and appropriate qualifier is required:  • EPSDT - PCS Services always require an ordering	For LA Medicaid other source is defined as the ordering provider.  Any provider entered as an ordering provider must be enrolled with LA Medicaid.  Note: LTPCS does not require an ordering provider but if no one is

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Locator #	Description	Instructions	Alerts
		provider	listed on the claim, it must be valid.
17a	Other ID#	<b>Situational</b> Complete if applicable. Enter the 7-digit Medicaid ID number of the ordering provider.	Enter the 7- digit Medicaid ID Number here.
17b	NPI#	<b>Situational</b> – Complete if applicable. Enter the NPI number of the ordering provider.	The 10-digit NPI Number is required.
18	Hospitalization Dates Related to Current Services	Optional.	
19	Additional Claim Information (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Leave Blank.	

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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.  0 ICD-10-CM  Required Enter the most current ICD diagnosis code.  NOTE: ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as non-primary diagnosis codes	The most specific diagnosis codes must be used. General codes are not acceptable.

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Locator #	Description	Instructions	Alerts	
22	Resubmission Code and/or Original Reference Number	Situational – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.  Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.  Appropriate reason codes follow:  Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other  Voids 10 = Claim Paid for Wrong Recipient/Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	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.	
23	Prior Authorization (PA) Number	<b>Required</b> – Enter the 9-digit prior authorization number for the authorized services.		
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	<b>Required</b> Enter the appropriate place of service code for the services rendered.		

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Locator #	Description	Instructions	Alerts
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	Required Enter the procedure code(s) for services rendered in the unshaded area(s).  Enter appropriate modifier with procedure code:  UB = LT-PCS EP = EPSDT-PCS	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number letter ("A", "B", etc.) in this block.  More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	Required Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> 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	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank.	
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient/beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers	

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Locator #	Description	Instructions	Alerts
		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	Leave Blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Practitioner or Supplier Including Degrees or Credentials	Optional – For the PCS CMS 1500, the practitioner or the practitioner's authorized representative's original signature is no longer required.  Required Enter the date of the	
32	Date Service Facility Location Information	signature.  Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	<b>Situational</b> – 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	Required – Enter the billing provider's 10-digit NPI number.	The 10-digit NPI Number must appear on paper claims.

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Locator #	Description	Instructions	Alerts
33b	Other ID #	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 <u>must</u> appear on paper claims.

Sample PCS Claim Form – See below.

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<b>16.28</b> <b>16.28</b>	Mail completed forms to:
HEALTH INSURANCE CLAIM FORM  APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	Gainwell Technologies P.O. Box 91020
POA	Baton Rouge, LA 70821
(Medicare#)   (	OTHER 1a. INSURED'S LD. NUMBER (For Program in Item 1) 1234567890123
	4. INSURED'S NAME (List Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Stress)  1234 ANYLANE  6. PATIENT FELÂTIONSHIP TO INSURED  Set X Spouse Onic One	7. INSURED'S ADDRESS (No., Street)
MYTOWN STATE & RESERVED FOR NUCC USE	CITY STATE
ZPCODE TELEPHONE (Include Area Code):	ZIP CODE TELEPHONE (Indude Area Oode)
70000 ( 225 ) 999-7777 9 OTHER INSURED S NAME (Last Name, First Name, Middle Initia) 10 IS PATIENT'S CONDITION RELATED TO	C. 11. INSURED'S POLICY GROUP OR FECA NUMBER
a OTHERINSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Quirent or Previous)	a. INSURED S DATE OF BIRTH SEX
IS RESERVED FOR NUCCUS AND DITO FINE FIXE	CITY  ZIP COCE  TELEPHONE (Indude Area Code)  ( )  C. 11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED S DATE OF BIRTH  DD D D D D D D D D D D D D D D D D D
c: RESERVED FOR NUCCUSE c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	DDOMBED
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize the release of any medical or other information necessary.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits after to myself or to his party who accepts assignment tallow.	services described below.
SIGNED DATE  14. DATE OF CURRENT ILLNESS, INJURY, O' PREGNAVCY (LMP) 15. OTHER DATE	46 DATES PATIENT LINARIE TO WORK INCURRENT ON PATION
14. DATE OF CURRENT ILLINESS INJURY, OF PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL MM DD YY	18 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION WM DD YY TO TO YY TO TO TO THE TOTAL TO TH
17 MAME OF REFERRING PROVIDER OF OTHER SOURCE 172 1234567 DK JOHN DOE, MD 172 NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRIENT SERVICES MM DD YY FROM TD TD
19. ADDITIONAL CLAIM INFORMATION (Designated by NJCC)	20. DUTSIDE LAB? \$ CHARGES
21 DIAGNOSIS CR NATURE OF ILLNESS CR INJURY Pelate A-L to service line below (24E) ICD Ind 0	22. RESUBMISSION ORIGINAL REF. NO.
A G808 B C D	23. PRIOR AUTHORIZATION NUMBER
EL GL HL	123456789
From To R.ACEOF (Explain Unusual Circumstances) DIAC	E. F. G. H. J.  ANOSIS DAYS PROT ID. RENDERING RANGES UNITS PM QUAL. FROMDER ID. #
03 01 19 03 01 19 12 T1019 EP	A 48 00   16   NPI
03 02 19 03 02 19 12 T1019 EP	A 45 00 15 NPI
03 05 19 03 05 19 12 T1019 EP	A 48 00 16 NP
03 06 19 03 06 19 12 T1019 EP	A 48 00 16 NPI  A 24 00 8 NPI
	NPI NPI
	NPI NPI
25 PEDERALTAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT ACCOUNT NO 1234 VIVES NO. 1234	(ENT?) 28 TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd.fcr NUCCUse
St. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR OPEDENTIALS (Location in Programme) (Locat	33. BLLING FROVIDER INFO & FH# (800) 233-3333 PCS AGENCY 700 MAIN ST
IMMA BILLER 03/08/19	ANY TOWN, LA 70000
SIGNED DATE <sup>a</sup> NUCC Instruction Manual available at www.nucc.co. PLEASE PRINT OR TYPE	■ 1326547895 ■ 1987654 APPROVED OMB-0936-1197 FORM 1500 (02-12)

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#### **Adjustments and Voids**

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.
- 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/Beneficiary/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient/beneficiary cannot be adjusted. They must be voided and corrected claims submitted.

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#### 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 PCS Claim Form Adjustment Form – See below.

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Montested   Mont	HEALTH INSURANCE CLAIM FORM PFROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 12/12		Mail completed forms to: Gainwell Technologies P.O. Box 91020 Baton Rouge, LA 70821	PICA TTT
1234 ANYLANE	2. PATIENT'S NAME (Last Name, First Name, Midde Initial)	B. PATIENT'S BETH DATE BEX	1234567890123	2/23/23/23/23/20/20
MYTOWN    STATE   S. RESERVED FOR MUCCUSE   CPT   STATE   CPT   CONTROL   CPT   CPT	Control of the Contro		7. INSURED'S ADDRESS (No., Street)	
Committee   Comm	75 A 2 A 2 A 2 A 2 A 2 A 2 A 2 A 2 A 2 A		спу	STATE
E. RESERVED FOR NUCCUSE  C. OTHER ACCUSESTY  C	70000 ( 225 ) 999-7777	0. IS PATIENT'S CONDITION RELATED TO:	( )	kre a Coole)
I INSURANCE PLAN NAME OF PROGRAM NAME  WITH AND CRESS (Dispyrated) by NUCC)  NOR PRINTED OF AUTHORIZED PERSONS SIGNATURE I authorize a service of any mat and content information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the doctor of program in accordance of any mat and order information recessory by process the control of program in a program in accordance of any mat and order information recessory by process the control of program in a program in accordance of any mat and order information recessory by process the program in accordance of any mat and order information recessory by process the program in accordance of any mat and order information recessory by process the program in a p	a RESERVED FOR NUCCUSSAMP	NES EXCEVA	b PAC All Pages by I	Total areas
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TO   TO   TO   TO   TO   TO   TO   TO			) 507 505 100	
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Price   Pric	E	н		
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S. FEDERAL TAX LD, NUMBER SIN BIN 28 PATIENTS ACCOUNT NO 127 ACCEPT ASSIGNMENT? 28 TOTAL CHARGE 29, ANDUNT PAID 10 Revolution NUCCUS 1234 22.00 \$  31. SIGNATURE OF PHYSICIAN OR SUFFILER INCLUDING DEGREES OR OFFICENTIALS (0 or fly inst the statements or not reverse apply to the DI and are made a part heliot)  MMA BILLER  03/29/19	03 01 19 03 01 19 12 11019	EP     A	42,00   14 NPI	RENDERING ROMDER ID. #
S. FEDERALTAX LD. NUMBER SIN EIR  22 PATIENT'S ACCOUNT NO 22 ACCEPT ASSIGNMENT? (Fig gaid claims, see bass)  1234  23 SERVICE FACILITY LOCATION INFORMATION  32 SERVICE FACILITY LOCATION INFORMATION  33 SELING FROWIDER INFO S PH # (800) 233-3333  PCS AGENCY 700 MAIN ST ANY TOWN, LA 70000			NPI NPI	
S. FEDERALTAX 1D. NUMBER  SIN EIN  28 PATIENT'S ACCOUNT NO  27 ACCEPT ASSIGNMENT'S  (Fig. glad.claims, see bass)  28 TOTAL CHARGE  29 AMOUNT PAID  30 Rivid for NUCCUs  42,00 g  43,00 g  44,00 g  44,00 g  44,00 g  44,00 g  45,00 g  46,00 g  46,00 g  47,00 g  48,00			NPI NPI	
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1234   X YES NO S 42 00 S			144.	
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PICA	A ODOLIN INCA OTHER	to INCLUDENCE IN AURICO		PICA (For Research in North 1)
MEDICARE MEDICAID TRICARE CHAMPV (Medicare#) (Medicaid#) (IDM/DoD#) (Member 8	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	4. INSURED'S NAME (Last No	ame, First Nem	e, Middle Initial)
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No	., Street)	
	Self Spouse Chiki Other		1	
Y STATE	8. RESERVED FOR NUCC USE	CITY		STATE
CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHO	ONE (Include Area Code)
( )			(	
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GRO	UP OR FECA	NUMBER
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRT	DH	SEX
ESERVED FOR NUCC USE	YES NO			M F
EGENTED FOR MODE USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designs	and by NUCC)	
SERVED FOR NUCC USE	G. OTHER ACCIDENT?	c. INSURANCE PLAN NAME	OR PROGRAM	I NAME
SURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d, IS THERE ANOTHER HEA	TH RENEET	DI ANS
SUITABLE PLAN INVINE ON PROGRAM INVINE	Total Country (Designation by Proces)	YES NO		plete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the	A SIGNING THIS FORM.	13. INSURED'S OR AUTHOR		'S SIGNATURE I authoriza signed physician or supplier fo
o process this claim. I also request payment of government benefits either	to myself or to the party who accepts assignment	services described below.	to to and distract	Manager of applying to
ielow.				
	DATE	SIGNED		
GIGNED	OTHER DATE MM DD VV	\$IGNED	TO WORK IN	CURRENT OCCUPATION
OGNED  ATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LMP) 15.  QUAL	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE MM DD FROM	T	ro
DATE OF CURRENT ILLNESS, INJURY, & PREGNANCY (LMP) 15.  QUAL QUAL QUAL 17.	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE	SRELATED TO YY	ro
BIGNED  DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMF)  TY  QUAL  NAME OF REFERRING PROVIDER OR OTHER SOURCE  176	OTHER DATE MM DD YY	18. DATES PATIENT UNABLE FROM DO	SPELATED TO	O CURRENT SERVICES
BIGNED  DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMF)  TY  QUAL  NAME OF REFERRING PROVIDER OR OTHER SOURCE  176  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	OTHER DATE MM DD YY	18. DATES PATIENT UNABLE FROM DO 18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB?	SRELATED TO	O CURRENT SERVICES MIM DO YY TO CHARGES
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE  176  DDITIONAL CLAIM INFORMATION (Designated by NUCC)	OTHER DATE MM DD YY	18. DATES PATIENT UNABLE FROM DO DO THE FROM DO THE FR	SPELATED TO	O CURRENT SERVICES MIM DO YY TO CHARGES
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)  OUAL  NAME OF REFERRING PROVIDER OR OTHER SOURCE  176  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	OTHER DATE MM DD YY  L NPI  Too line below (24E) ICD Ind.	18. DATES PATIENT UNABLE FROM DO	S RELATED TO	O CURRENT SERVICES MIM DO YY TO CHARGES
DIGNED  ATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  AND DIGNES OF REFERRING PROVIDER OR OTHER SOURCE 176  172  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relatis A-L to serv  B	OTHER DATE  AL  DD YY  Toe line below (24E)  ICD Ind.  D.  H.  L  DURES, BERVICES, OR SUPPLIES  E.	18. DATES PATIENT UNABLE FROM DO 18. HOSPITALIZATION DATE FROM 20. OUTSIDE LAB?  YES NO 22. RESUBMISSION 23. PRIOR AUTHORIZATION	S RELATED TO YY  T  S  ORIGINAL  NUMBER	O CURRENT SERVICES MIM DO YY TO CHARGES
ATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  AND ATTERSOR NATURE OF ILLNESS OR INJURY Relate A-L to serve the serve that the	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD Ind.  D.  H.  L  DURIES, SERVICES, OR SUPPLIES In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	S RELATED TO YY  T  S  ORIGINAL  NUMBER	O CURRENT SERVICES MM DO YY  CHARGES  REF. NO.
AGRICO TO PROPERTY ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  DDITIONAL CLAIM INFORMATION (Designated by NUCC)  MAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serve B. C. L.  F. G. L.  A. DATE(S) OF SERVICE B. C. D. PROCE (Explic	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  ORIGINAL  NUMBER  BERT ID.  FROM ID.	O CURRENT SERVICES MM DO Y  CHARGES  REF. NO.  REP. NO.  PROVIDER ID. #
ATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  AND ATTURE OF ILLNESS OR INJURY Relate A-L to serve the serve that the serve th	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  ORIGINAL  NUMBER	O CURRENT SERVICES MM DO Y  CHARGES  REF. NO.  REP. NO.  PROVIDER ID. #
AGRICO TO PROPERTY ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  DDITIONAL CLAIM INFORMATION (Designated by NUCC)  MAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serve B. C. L.  F. G. L.  A. DATE(S) OF SERVICE B. C. D. PROCE (Explic	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  ORIGINAL  NUMBER  BERT ID.  FROM ID.	O CURRENT SERVICES MM DO Y  CHARGES  REF. NO.  REF. NO.  PROVIDER ID. #
AGRICO TO PROPERTY ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  DDITIONAL CLAIM INFORMATION (Designated by NUCC)  MAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serve B. C. L.  F. G. L.  A. DATE(S) OF SERVICE B. C. D. PROCE (Explic	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  ORIGINAL  MUMBER  B PROT ID.  From CUA	O CURRENT SERVICES MM DD Y  CHARGES  REF. MO.  REP. MO.  PROVIDER ID. #
AGRICO TO PROPERTY ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  DDITIONAL CLAIM INFORMATION (Designated by NUCC)  MAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serve B. C. L.  F. G. L.  A. DATE(S) OF SERVICE B. C. D. PROCE (Explic	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  ORIGINAL  NUMBER  H. I. SPECTION GUA	O CURRENT SERVICES MM DD Y  CHARGES  REF. MO.  REP. MO.  PROVIDER ID. #
ATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  M DD YY QUAL  AME OF REFERRING PROVIDER OR OTHER SOURCE 176  176  AND ATTURE OF ILLNESS OR INJURY Relate A-L to serve the serve that the serve th	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  ORIGINAL  MUMBER  B PROT ID.  From CUA	O CURRENT SERVICES MM DD Y  CHARGES  REF. NO.  REP. NO.  REP. NO.
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  MIN DD YY QUAL  NAME OF REFERRING PROVIDER OR OTHER SOURCE 176  178  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serve B. C. L.  F. G. L.  J. K. L.  From To PUSEOF DEPOCE (Explicit County Property Co	TOTHER DATE  AL  INPI  Ice line below (24E)  ICD ind.  D.  H.  L  DURIES, BERVICES, OR SUPPLIES  In Unusual Circumstances)  DIAGNOSIS	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. Q. DAYNOR	ORIGINAL  MUMBER  S H. I. I. S PROTI ID. S	O CURRENT SERVICES MM DD Y  CHARGES  REF. NO.  REP. NO.  PROVIDER ID. #
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DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.  IN AME OF REFERRING PROVIDER OR OTHER SOURCE 176  ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relatis A-L to serv  B	TOTHER DATE MM DD YY  Ice line below (24E) ICD Ind. D. H. L DURIES, SERVICES, OR SUPPLIES In Unusual Circumstances) CS MODIFIER DIAGNOSIS POINTER  ACCOUNT NO. 27. ACCEPT ASSIGNMENT? W got dams, see bad?	18. DATES PATIENT UNABLE FROM DO THE FROM	ORIGINAL MUMBER  S PROTI ID. S PROTI ID. NPI	O CURRENT SERVICES MM DD YY  O CHARGES  REF. NO.  REP. NO.
ADDITIONAL CLAIM INFORMATION (Dissignated by NUCC)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service B. C. L. K. L. A. DATE(S) OF SERVICE PRODUCY MM DD YY SERVICE EMG. CPT/HCP	OTHER DATE  AL  IDURES, SERVICES, OR SUPPLIES In Unusual Circumstances) CS MODIFIER  DIAGNOSIS POINTER	18. DATES PATIENT UNABLE FROM DO 19. HOSPITALIZATION DATE FROM DO 20. OUTSIDE LAB?  20. OUTSIDE LAB?  YES NO 22. RESUBMISSION  23. PRIOR AUTHORIZATION  F. DAY OR ON	ORIGINAL NUMBER  ORIGINAL NUMBER  H. I.	O CURRENT SERVICES MM DD YY  O CHARGES  REF. NO.  REP. NO.