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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING PAGE(S) 14

CLAIMS FILING

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:

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 web site at www.lamedicaid.com, 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.

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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'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 must 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	Required – 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	Optional – 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		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Leave Blank.	

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Locator #	Description	Instructions	Alerts
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.	
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	Optional.	

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Locator #	Description	Instructions	Alerts
17a	Unlabeled	Optional.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
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 on or after 10/1/15. 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)

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Locator #	Description	Instructions	Alerts
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 99 = 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 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	Required – 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	Required Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank.	

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CHAPTER 30: PERSONAL CARE SERVICES

Locator #	Description	Instructions	Alerts
		Required Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24D	Procedures, Services, or Supplies	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	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. 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. 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	Leave Blank.	

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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING PAGE(S) 14

Locator #	Description	Instructions	Alerts
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional – The practitioner or the practitioner's authorized representative's original signature is no longer required. 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 <u>must</u> appear on paper claims.

Sample forms are on the following pages.

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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING **PAGE(S) 14**

PCS – Example Claim Form with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

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		YNATI						UCC) 02/12													PICA	
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						e, Middle	Initial)		3. PATIENT'S	BIRTH I	4		EX	4. INSURED'S			ne, Firs	t Name,	Middle	Initial)		
		, PA							01 (5 5	5 M		F	7 INCLIDED:	ADDDE	00 (N-	Ctront					
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O C	DDE			TE	LEPHO	NE (Inclu	de Area	Code)						ZIP CODE			TEL	EPHON	E (Indu	de Area	Code)	_
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RES	ERVE	D FOR	NUCC (JSE					O HER AC	CIDENT	ļ	NO.		c. INSURANCE	PLANI	NAME O	R PRO	GRAM N	NAME			_
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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING **PAGE(S) 14**

PCS – Example Claim Form with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

国際国		
HEALTH INSURANCE CLAIM FORM		
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/1	2	
PICA		PICA TITLE
MEDICARE MEDICAID TRICARE CHAMI	PVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare #) X (Medicaid #) (ID#/DoD#) (Membe	HEALTH PLAN BLK LUNG er ID#) (ID#) (ID#) (ID#)	1234567891234
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
REVERE, PAUL	01 05 55 M × F	The state of the s
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)
J. PATIENT GABBAESS (No., STOR)	Self Spouse Child Other	7. 1100 E 20 7 E 20 7 F
CITY STAT	E 8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Indude Area Code)	_	ZIP CODE TELEPHONE (Include 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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCCUSE	YES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIMID (Designated by NUCC)
	CARADIE	ZIP CODE TELEPHONE (Include Arina Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BRITH MM DO MM F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. ISTHERE ANOTHER HEALTH BENEFIT PLAN?
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO 10d. RESERVED FOR LOCAL USE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	108. RESERVED FOR LOCAL USE	
	MADLE CIET	Tyes, complete items 9, 9a and 9d.
READ BACK OF FORM BE ORE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 AUTHORIZED	the release of any medical of other information necessary	INSURED SOME THE RESEARCH 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 eith below.	er to myself or to the party who accepts assignment	services described below.
SIGNED	DATE	SIGNED
MM DO YY	5.OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD YY TO MM DD YY TO MM DD YY
<u> </u>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
ľ	1b. NPI	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO
21. DIAGNOSIS OR NATURE OF ILL NESS OR INJURY Relate A-L to	service line below (24E) ICD Ind. 0	22. RESUBMISSION ORIGINAL REF. NO.
A. [J029 B. [C		CODE CHICINAL REP. NO.
E. I F.I G		23. PRIOR AUTHORIZATION NUMBER
		Prior Auth#
I. J. K 24. A. DATE(S) OF SERVICE B. C. D.PRC	OCEDURES, SERVICES, OR SUPPLIES E.	
From To PLUCEOF (()	Explain Unusual Circumstances) DIA GNOSIS ICPCS MODIFIER POINTER	S CHARGES UNITS PROVIDER ID. #
10 08 15 10 08 15 12 T10	019 UB A	60 00 20 NPI
10 00 10 10 12 110	710 00	00 00 20 1
10 09 15 10 09 15 12 T10	019 UB A	96 00 32 NPI
		NPI NPI
		MEI
		NPI NPI
		F. DAYS BY SET ID. RENDERING PROVIDER ID. # 1.0. RENDERING PROVIDE
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT	'S ACCOUNT NO. 27. ACCEPT, ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234	"S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. dalms, see back) X YES NO	s 156 00 s s 156 00
1.20	FACILITY LOCATION INFORMATION	
INCLUDING DEGREES OR CREDENTIALS	THE PROPERTY OF THE OWNER OF THE PARTY OF TH	(555)22
(I cartify that the statements on the reverse apply to this bill and are made a part thereof.)		A VERY RELIABLE PCS AGENCY
The state of the s		123 MAIN ST
Inc. Billion		ANY TOWN, LA 70000
SIGNED Ima Biller DATE 10/15/15 a.	b.	a. 123967654 b. 1239876
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02-12

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APPENDIX J: CLAIMS FILING PAGE(S) 14

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/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.

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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 J: CLAIMS FILING

PAGE(S) 14

PCS – Example Adjustment Form with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

](영민 왕조) 1823년		
EALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC	1) 02(42	
PICA	.) 02/12	PICA
. MEDICARE MEDICAID TRICARE C	HAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	Member ID#) (ID#) (ID#) (ID#)	1234567891234
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
REVERE, PAUL PATIENT'S ADDRESS (No., Street)	01 05 55 M X F 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
PATIENT S ADDRESS (No., Silver)	Self Spouse Child Other	7. House or about to the transfer of the trans
пү	STATE 8. RESERVED FOR NUCC USE	CITY
P CODE TELEPHONE (Include Area Code	e)	ZIP CODE TELEPHONE (Indude Area Code)
()		()
OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	al) 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
	YES NO	M F
RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	-SAMPLE	c. INSURANCE PLAN NAME OR PROGRAM NAME
TON HOUSE OF THE PARTY OF THE P	C O I PER ACCIDENTY	A STATE OF THE STA
NSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d, ISTHERE ANOTHER HEALTH BENEFIT PLAN?
F)	(AMPLE OF IC	YES NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMP PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I auth to process this claim. I also request payment of government benefi		INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED	DATE	SIGNED
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMF		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	FROM TO 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 Relate	A-L to service line below (24E) ICD Ind. 9	YES NO 22. RESUBMISSION ORIGINAL REF. NO.
. 1462 B.I	C D.	CODE ORIGINAL REF. NO. 4094198765401
F.	G. H.	23. PRIOR AUTHORIZATION NUMBER
J.	K L	987654321
From To PLACE OF	D.PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS CPT/HCPCS MODIFIER DIAGNOSIS	F. G. H. I. J. DAYS Penty ID. RENDERING S CHARGES UNITS Pain QUAL. PROVIDER ID. #
4 03 14 04 03 14 12	T1019 UB A	84 00 28 NPI
		NPI NPI
		NPI
		NPI
<u> </u>		
		NPI NPI
		NPI
	FIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
FEDERAL TAX I.D. NUMBER SSN EIN 26. PAT	V VEC NO	84 00 6
	X YES NO	\$ 84 00 \$ \$ \$ 33. BILLING PROVIDER INFO & PH# (800) 222-3333
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SER	X YES NO RVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (800) 222-3333
. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SEF	X YES NO	33. BILING PROVIDER NFO & PH# (800) 222-3333 A VERY RELIABLE PCS AGENCY 123 MAIN ST.
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR OREDENTIALS (I certify that the statements on the reverse	X YES NO	33. BILLING PROVIDER INFO & PH# (800) 222-3333 A VERY RELIABLE PCS AGENCY

ISSUED: 09/28/15 **REPLACED:** 04/30/14

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS FILING

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PCS - Example Adjustment Form with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

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2. P/	١TI	ENT'S	NAME	(Last N	lame, Fi	irst Nam	e, Middle	Initial)	3.	PATIENT MM	S BIRTI	H DATE YY		SEX	4. INSURED'S NAME	(Last Nar	ne, First	Name, Mid	de Initial)	
RE	٧	ERE,	PA	UL						01 (05		١×	F						
5. P/	ΛTI	ENT'S	ADDR	ESS (N	o., Stree	et)				PATIENT					7. INSURED'S ADDR	ESS (No.,	Street)			
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		OE.			- 1''	,) J	108 A 88	COM)						ZIFCODE		1000	()	CIGGO AIG	10000)
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.0	ГН	ER INS	URED	'S POLI	CY OR	GROUP	NUMBE	R	a.	EMPLOY	MENT?		r Previo	ius)	a INSURED'S DAT	E OF BIR	тн	м	SEX	F
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to		ocess th		JTHOR	IZED PE	ERSON'	FORM BE S SIGNA nt of gove	UKE	authorize the releasements either to m	an IC sase of an yself or to	medicate the party	ar or other y who a co	informa opts assi	sion necessary ignment	payment of medica services described	al benents	to the u	RSON'S SIG indensigned	NATURE physician	l authorize or supplier for
S	IG	NED								DA	TE				SIGNED					
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7. N	Αı	WE OF F	RÉFEF	RRING	PROVID	ER OR	OTHER	SOURC	17a. 71b. Ni	PI					18. HOSPITALIZATION	N DATES	RELAT	ED TO CUR TO	RENT SE	RVIÇEŞ
9. A	DO	OITION/	AL CL/	AM INF	ORMAT	TION (De	esignated	by NUC	C)						20. OUTSIDE LAB?	,, l		\$ CHARGE	ES	<u> </u>
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ISSUED: 09/28/15 REPLACED: 04/30/14

CHAPTER 30: PERSONAL CARE SERVICES

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Sample Claim Form

ALTH INSURAL ROVED BY NATIONAL UNIFO			12							
PICA		2 6								PICA
MEDICARE MEDICAID	TRICARE	CHAM	- HEALTH	PLAN FECA	G	1a. INSURED'S I.D	NUMBER		(F	or Program in Item 1)
(Medicares) (Medicalds		(Memb	er (DW) (IDW)	(ID#)	(IDII)					
ATIENT'S NAME (Last Namo,	First Name, Middle In	ittel)	3. PATIENT'S BI	HTH DATE	SEX F	4. INSURED'S NAM	IE (Last Na	me, First	Name, Midd	do Initial)
ATIENT'S ADDRESS (No., St	est)		6. PATIENT REI	ATIONSHIP TO INS	10.0	7. INSURED'S ADD	RE88 (No.,	, Street)		
			Self Spo	ouse Child	Other			4		
		STAT	E 8. RESERVED F	OR NUCC USE		CITY				STATE
CODE	TELEPHONE (Includ	lo Area Code)				710 0000		TELE	DUDNE (In	dude to Code
A.C.	()	a rusa coda)				ZIP CODE		1)	clude Area Code)
THER INSURED'S NAME (LE	st Name, First Name,	Middle Initial)	10. IS PATIENT	S CONDITION RELA	TED TO:	11. INSURED'S PO	LICY GROU	JP OR FE	CA NUMBE	9 R
	3 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -								A	
THER INSURED'S POLICY C	R GROUP NUMBER		a. EMPLOYMEN	IT? (Current or Previ		a. INSURED'S DAT	F OF BIRT	н		SEX
ESERVED FOR NUCC USE			b. AUTO ACCID	YES NO		h OTHER CLASS	n marian	and the state	M	F
			3.70.00	YES N	PLACE (State)	b. OTHER CLAIM I	n American	ed by NU	Liu)	
SERVED FOR NUCC USE			c. OTHER ACC	DENT?		c. INSURANCE PL	N NAME C	PROG	RAM NAME	ŧ
				YES NO)		100			
SURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM COL	XES (Designated by	NUCC)	d. IS THERE ANOT	100			
READ	BACK OF FORM BEF	ORE COMPLET	ING A SIGNING THE	FORM.		13. INSURED'S OR	AUTHORIZ	10/10/70 000		ms 9, 9a, and 9d. NATURE I authoriza
ATIENT'S OR AUTHORIZED process this claim. I also req	PERSON'S SIGNATI lest payment of govern	URE I authorize t	he release of any med her to myself or to the	lical or other informati party who accepts as	on necessary	payment of med services describ	ical benefits	to the ur	deralgned p	physician or supplier for
alow.										
IGNED			DATE		<u> </u>	SIGNED				
ATE OF CURRENT ILLNES	AL INJURY, OF PREGN		5. OTHER DATE	MM DD	YY	18. DATES PATIEN MM FROM	DO	TO WOR	K IN CURR MA	IENT OCCUPATION
AME OF REFERRING PRO		OURCE -	17g.			18. HOSPITALIZAT	ON DATES	RELATE		RENT SERVICES
			17b. NPI			FROM			то	
DOITIONAL CLAIM INFORM	ATION (Designated b	y NUCC)				20. OUTSIDE LAB?	4 0.000		\$ CHAR	GES
HAGNOSIS OR NATURE OF	ILLNESS OF INJURY	/ Relate A-L to s	ervice line below (245	and the		22. RESUBMISSIO	NO	GF1190	or respect	
	В.	C	A CONTRACTOR OF THE PARTY OF TH	ICD Ind.		CODE		ORIGI	NAL REF. N	NO.
	F.	_ a	10	н		23. PRIOR AUTHO	PIZATION P	NUMBER		
	J. I	_ к	100	L L						
	o PLACEOF	(E)	CEDURES, SERVICI piain Unusual Circun	rstances)	E. DIAGNOSIS	F.	DAYS OR UNITS	H. EPSOT Ferrily Plan	I. ID.	J. RENDERING
DD YY MM D	D YY SERVICE	EMG CPT/H	CPCS	MODIFIER	POINTER	\$ CHARGES	UNITS	Plan	QUAL	PROVIDER ID. #
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CLUDING DEGREES OR C certify that the statements or	the reverse									
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