5

5 Filing Claims

Because Medicaid cannot make payments to recipients, the provider who performed the service must file an assigned claim and agree to accept the allowable reimbursement as full payment.

Federal regulations prohibit providers from charging recipients, the Alabama Medicaid Agency, or HP a fee for completing or filing Medicaid claim forms. The cost of claims filing is considered a part of the usual and customary charges to all recipients.

Effective March 1, 2010, all claims which do not require attachments or an Administrative Review override by Medicaid must be submitted electronically. This chapter provides basic information for filing claims. The information is not specific to provider type; it is intended to give all providers an understanding of the various methods for claims submission and instructions on completing claims forms. Once you understand the information in this section, you can refer to the chapter in Part II that corresponds to your provider type for additional claims filing information.

This chapter contains the following sections:

- *Before You Submit Your Claim,* which describes how claims are processed, which claim forms are approved for submission to Medicaid, and other general claim-related information
- *Completing the CMS-1500 Claim Form*, which provides detailed billing instructions for the CMS-1500 claim form
- *Completing the UB-04 Claim Form*, which provides detailed billing instructions for the UB-04 claim form
- *Completing the ADA Dental Claim Form*, which provides detailed billing instructions for the ADA Dental claim form
- *Completing the Pharmacy Claim Form*, which provides detailed billing instructions for the Pharmacy claim form
- *Crossover Claim Filing*, which provides billing instructions for the medical claim form. **Please note that for an administrative or manual review Alabama Medicaid requires paper crossovers for professional claims to be submitted using the approved Medical Medicaid/Medicare-related crossover claim form. Institutional providers should use the UB-04 claim form for crossovers.**

  The crossover claim is also to be used to file claims in which the primary payer is a Medicare Advantage plan. When a recipient is enrolled in a Medicare Advantage plan and Medicaid has **not** paid a monthly capitation payment, providers must file a crossover claim when billing Medicaid for any Medicare Advantage deductible, coinsurance or copay. Follow the instructions in section 5.4 or 5.6.2.

Added: The crossover claim…section 5.4 or 5.6.2.

- *Required Attachments*, which lists and describes the Alabama Medicaid required attachments
- *Adjustments,* which provides instructions for submitting online adjustments.
- *Refunds,* which provides instructions on receiving refunds
- *Inquiring about Claim and Payment Status,* which describes various methods for contacting HP to inquire about claim and payment status

5.1 Before You Submit Your Claim

This section discusses claim types, how HP processes claims, and the various methods for submitting claims. It includes the following topics:

- Valid Alabama Medicaid claim types
- How claims are processed
- Methods for submitting claims with attachments
- Electronic claims submission
- Filing limits and approved exceptions
- Recipient signatures
- Provider signatures

5.1.1 Valid Alabama Medicaid Claim Types

Alabama Medicaid processes eight different claim types (Managed Care claims are described in Chapter 39, Patient 1st). The claims must be submitted in electronic format. Alabama recognizes two standard claim forms (UB-04 and CMS-1500) and three Medicaid non-standard claim forms (Pharmacy, Dental, and one Medicare/Medicaid-related claim form). The provider's provider type determines which claim type to bill, as illustrated in the table below.

Claim Type	***Claim Form***	***HIPAA Transaction***	***Providers Who Bill Using This Claim Type***
Medical	CMS-1500	837 Professional	• Physicians • Physician Employed Practitioners (CRNP and PA) • Independent Labs • Independent Radiology • Transportation • Prosthetic Services • DME • Podiatrists • Chiropractors • Psychologists • Audiologists • Therapists (Physical, Speech, Occupational) • Optometrists/Opticians • Optical Dispensing Contractor • Clinics • Rural Health Clinics (IRHC, PBRHC) • FQHC • County Health Departments • Targeted Case Management • Independent Nurse Practitioner • Hearing Aid Dealer • Waiver Services (Homebound, Elderly and Disabled, MR/DD) • Maternity Care • State Rehab Services (Mental Health Centers, DYS, DHR) • CRNA • Nurse Midwife
Dental	2006 ADA	837 Dental	Dentists/Oral Surgeons when billing CDT codes
Pharmacy	XIX-BC-10-93	NCPDP	Pharmacists
Inpatient	UB-04	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient	UB-04	837 Institutional	• Hospitals • Ambulatory Surgical Centers (straight Medicaid) • Hemodialysis • Private Duty Nursing • Hospice Facility • Home Health Services • Lithotripsy (ESWL)
Medical crossover	Medical Medicare/Medicaid-Related Claim	837 Professional	All providers listed under the medical claim type • Ambulatory Surgical Centers (crossover claims)

5.1.2 How Claims are Processed

This section briefly describes claims processing, from assigning a unique tracking number to a claim, to generating and mailing the payment.

Internal Control Number

All claims entered into the HP system for processing are assigned a unique 13-digit Internal Control Number (ICN). The ICN indicates when the claim was received and whether it was sent by paper or through electronic media. The ICN is used to track the claim throughout processing, on the Remittance Advice (RA), and in claims history.

For more information about the ICN numbering system used for claims processing, refer to Appendix F, Medicaid Internal Control Numbers.

Claims Processing

HP verifies that the claim contains all of the information necessary for processing. The claim is processed using both clerical and automated procedures.

First, the system performs validation edits to ensure the claim is filled out correctly and contains sufficient information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met.

For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider.

The system then performs the National Correct Coding Initiative (NCCI) procedure to procedure and medically unlikely edits.

Once claims pass through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policy and performs cost avoidance. Cost avoidance is a method that ensures Medicaid is responsible for paying for all services listed on the claim. Because Medicaid is the payer of last resort, the system confirms that a third party resource is not responsible for services on the claim.

The system then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compares them to Alabama Medicaid policy.

The system then prices the claim using a State-determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claims processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time a Remittance Advice (RA) report is produced and checks are written, if applicable. Suspended claims must be worked by HP personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the checkwriting schedule published in the *Provider Insider*, the Alabama Medicaid provider bulletin produced by HP. The check is sent to the provider's payee address. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the provider's bank account. Effective March 1, 2010, Medicaid no longer prints and distributes

paper Remittance Advices (RAs) to providers. RAs are described in Chapter 6, Receiving Reimbursement.

5.1.3 Methods for Submitting Claims

HP accepts all claims which do not require attachments or an Administrative Review override by Medicaid in electronic format. Paper claims submitted for an administrative or manual review must be submitted using the approved claim formats listed in the table in Section 5.1.1, Valid Alabama Medicaid Claim Types.

To improve hard copy claims processing, HP now scans paper claims and performs Optical Character Recognition (OCR) to enter data from the claims into the Medicaid system. All CMS-1500 and UB-04 paper claims must be submitted using red dropout forms. The scanner drops any red or blue markings on the claim form, leaving only the data the provider entered on the claim form.

NOTE:

All claim forms must be completed in dark **BLACK** ink. Do not circle, underline, or highlight any information on the claim. **Send original claim forms only;** do not send copies.

Providers should submit typewritten or computer-generated paper claims whenever possible to speed up the data entry process. Keep in mind the following guidelines:

- Make sure typed information does not fall outside the specific boxes.
- Change printer ribbons often, since claims with print too light to be scanned will be returned.

Providers can obtain Medicaid/Medicare-related claim forms free of charge from HP.

5.1.4 Electronic Claims Submission

Electronic claims may be submitted using a variety of methods:

- Provider Electronic Solutions software, provided at no charge to Alabama Medicaid providers
- Value Added Networks (VANs) or billing services on behalf of an Alabama Medicaid provider
- Tapes or other electronic media, as mutually agreed to by the Alabama Medicaid Agency and the vendor

Electronic Claims Submission (ECS) offers providers a faster and easier way to submit Medicaid claims. When you send your claims electronically, there is no need to complete paper Medicaid forms. Your claim information is submitted directly from your computer to HP.

If filing claims using the PES software, please refer to the Provider Electronic Solutions User Manual for the appropriate claim filing instructions and values.

Electronic claims begin processing as soon as they are received by the system. Paper claims must go through lengthy processing procedures, which could result in delayed payment on the claims. An electronically submitted claim displays on the next Remittance Advice (RA) following the claim submission. Unless your claim suspends for medical policy reasons, it should finalize (pay or deny) in the checkwriting step.

All of the Electronic Claims Submission (ECS) options are provided free of charge. Providers also have the option of using software from a software vendor or programmer. HP furnishes file specifications at no charge. **If you have further questions or wish to order software, contact the HP Electronic Claims Submission (ECS) Help Desk at 1(800) 456-1242** (out of state providers call (334) 215-0111).

5.1.5 Filing Limits and Approved Exceptions

Generally, Medicaid requires all claims to be filed within one year of the date of service; however, some programs have different claims filing time limit limitations. Refer to your particular provider type program chapter for clarification.

Claims more than one year old may be processed under the following circumstances:

- Claims filed in a timely manner with Medicare or other third party payers may be processed if received by the fiscal agent within 120 days of the third party disposition date. These claims may be filed electronically. Providers should enter the TPL paid date in the appropriate field. The HP claims processing system will then compare the TPL paid date to the assigned ICN; if the claim is received within 120 days it will process. Claims for services rendered to a recipient, during a retroactive eligibility period, may be processed if received by the fiscal agent **within one year** from the date of the retroactive award. Providers must submit these claims electronically.

- Claims for services that were previously paid by Medicaid and later taken back, either at Medicaid's request or the provider's request, may be processed if received by the fiscal agent **within 120 days** of the recoupment. This date must be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider in the following format: "Recouped Claim 11-01-02" or "Recouped Claim Nov. 1, 2002". A copy of the Medicaid Remittance Advice (RA), showing the recoupment and the date must be attached to the claim.

NOTE:

This section shall not apply to claims recouped through medical record reviews and/or investigations. Recouped claims from medical record reviews and/or investigations are considered final and are not subject to resubmission. Medical record reviews include, but are not limited to those performed by: the Medicaid Program Integrity Division, the Recovery Audit Contractor (RAC), the Medicaid Integrity Contractor (MIC) and Payment Error Rate Measurement (PERM) contractor.

Submit claims more than one year old that meet the above criteria, to the following address:

HP Provider Assistance Center
P.O. Box 244032
Montgomery, AL 36124-4032

NOTE:

Refer to Section 7.2.1, Administrative Review and Fair Hearings, for more information regarding administrative reviews.

5.1.6 Recipient Signatures

While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, (such as release forms or sign-in sheets) as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below:

- The recipient signature is not required when there is no personal contact between recipient and provider, as is usually the case for laboratory or radiology.
- Illiterate recipients may make their mark, for example, "X," witnessed by someone with his dated signature after the phrase "witnessed by."
- A representative may sign for a recipient who is not competent to sign because of age, mental, or physical impairment.
- The recipient signature is not required when a physician makes a home visit. The physician must provide documentation in the medical record that the services were rendered.
- For services rendered in a licensed facility setting other than the provider's office, the recipient's signature on file in the facility's record is acceptable.

NOTE:

The use of Sign-In Sheets, as verification that the recipient was present on the date of service for which the provider seeks payment, is permissible under the Privacy Rule, but should be limited to the minimum necessary. For example, it should not have a column asking for "reason for visit." A provider's sign-in sheet may simply ask for the patient's name and nothing more.

5.1.7 Provider Signatures

This section discusses the various requirements for provider signatures when filing electronic or hard copy claims.

Medical Claims

The provider's signature on a claim form/medical submission agreement or the Provider Agreement certifies that the services filed were performed by the provider or supervised by the provider and were medically necessary.

NOTE:

Prior to October 1999, individual practitioners (not groups or clinics) may have signed a Medical Claims Submission Agreement with Medicaid for the submission of paper claims instead of signing individual claim forms. Effective October 1, 1999, the Medical Claims Submission Agreement was incorporated into the Alabama Medicaid Provider Agreement which must be completed and signed by all providers.

By signing the Provider Agreement, the provider agrees to keep any records necessary to enable the provider to perform the following responsibilities:

- Disclose the extent of services the provider furnishes to recipients
- Furnish Medicaid, the Secretary of HHS, or the state Medicaid Fraud Control Unit, upon request, any information regarding payments received by the provider for furnishing services
- Certify that the information on the claim is true, accurate, and complete, and the claim is unpaid
- Affirm the provider understands that the claim will be paid from federal and state funds, and any falsification or concealment of a material fact may be prosecuted under federal and state laws

Providers who have either a completed Medical Claims Submission Agreement or Provider Agreement on file should place the words "**Agreement on File**" in block 31.

The individual practitioner may also personally sign the claim form in the appropriate area and must initial the claim form beside a typewritten or stamped signature. An individual practitioner's name or initials may be signed by another person who has power of attorney from the practitioner.

Tape Billers

Providers submitting claims through a tape biller must have a contract on file with HP signed by the provider or the billing agent authorizing tape submission of claims.

Tapes that HP receives must be accompanied by a transmittal form signed by the billing provider or the billing agent.

Electronic Billers

Providers billing electronically must have a contract signed by the provider on file with HP. When applicable, the billing agent's signature must also appear on the contract.

Diskette Billers

Providers submitting claims on diskette to HP must have a contract signed by the provider on file with HP.

Computer Generated Claim Forms

Computer generated claim forms may be submitted with the provider's name generated on the form. In which case, the provider’s handwritten name or initials must accompany the name.

"Agreement on File" may also be printed on computer generated claim forms in lieu of the provider's signature, if either a Medical Claim Submission Agreement or Provider Agreement is on file.

The policy provisions for provider signatures can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 1.

5.1.8 Submitting Paid and Partially Paid Claims to Medicaid

Providers may submit paid, partially paid, and deductible applied third party claims to Medicaid using the approved paper or online filing methods as described in Chapter 5, Filing Claims. Additionally, to capture third party payment information, a TPL panel (for electronic claims) or a Medicaid Other Insurance Attachment form (for paper claims) is required to provide the other payer amounts that were applied to the following: paid amount, deductible amount, coinsurance amount, and co-pay amount. Completion instructions for the TPL panel may be found in the Provider Electronic Solutions (PES) User Guide and the interactive Service-Web User Guide. Completion instructions for the Medicaid Other Insurance attachment form may be found in section 5.8 of this chapter. **The following third party-related information is also required on the claim,** in addition to the other required claim data:

Claim Form	***Include the Following Third Party Information***	***In These Claim Fields***
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL paid dates	• Blocks 9-9d • Block 10 • Block 19
UB-04	• Other payer name • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL paid date	• Block 50 • Block 58 • Block 60 • Block 61 • Block 62 • Block 73 • Block 80
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Policyholder/Subscriber ID (SSN or ID#) • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL payment	• TPL carrier information • TPL payment/denial information

NOTE:

The Medicaid Other Insurance Attachment form is not required in addition to the Pharmacy claim form.

NOTE:

Failure to list the third party payment in the appropriate space on the claim may result in a denied claim.

If the claim is less than one year old and the other payer processed a payment or applied all the allowed charges toward the patient's responsibility, (ie. deductible, coinsurance, or co-pay), then the claim may be submitted electronically and Medicaid does not require the attachment of the third party Remittance Advice (RA) Claims more than one year old may be submitted electronically if 1) the third party payer has made a payment or applied the charges toward patient responsibility and 2) the claim submission date is within 120 days of the third party payment. If a claim is more than one year old and the third party payer has denied the claim, the claim must be submitted on paper, along with an attached copy of the third party Remittance Advice (RA). Claims more than one year old must be submitted within 120 days of the third party payment.

Claims meeting the requirements for Medicaid payment will be paid in the following manner if a third party payment is indicated on the claim:

- Other payer patient responsibility amounts (the deductible, coinsurance, and co-pay amounts) will be captured by Medicaid and used in determining the amount of Medicaid payment. In order for claims to be considered for payment, the patient responsibility must be greater than zero or the claim will be denied with the denial message "TPL Patient Responsibility is Zero for payor". Patient responsibility will be calculated by adding together any co-payment, coinsurance, and deductible.
- For professional claims, other payer amounts will be captured at the header and the detail levels. The total submitted at the header should balance the totals submitted at the detail. Medicaid will pay the lesser of the other payer patient responsibility or the Medicaid allowed amount minus the other payer paid amount.
- Other payer-paid amounts exceeding the Medicaid allowed amount will receive no further payment from Medicaid. Medicaid will place a zero paid amount on the claim and include an explanatory EOB code on the Remittance Advice (RA). **Patients cannot be billed under this condition.**

The Medicaid Other Insurance Attachment form is required only when a claim must be submitted on paper for administrative or manual review, and third party insurance has made a payment or applied charges to patient responsibility.

NOTE:
Providers cannot charge the recipient for other insurance co-pays when the service is billed to Medicaid. As stated above, other payer co-pays, coinsurance, and deductibles are to be submitted to Medicaid as other payer patient responsibility amounts and are considered for payment during Medicaid's claims processing.

5.1.9 Submitting Denied Claims to Medicaid

Providers may submit denied third party claims to Medicaid. **The following third party-related information is required on the claim,** in addition to the other required claim data:

Claim Form	*Include the Following Third Party Information*	*In These Claim Fields*
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL denied dates	• Blocks 9-9d • Block 10 • Block 19

Claim Form	*Include the Following Third Party Information*	*In These Claim Fields*
UB-04	• Other payer name • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL denied date	• Block 50 • Block 58 • Block 60 • Block 61 • Block 62 • Block 73 • Block 80
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Policyholder/Subscriber ID (SSN or ID#) • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code • TPL Denial Date (with EOB ATTACHED)	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11 • Block 35 Remarks
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL denial	• TPL carrier information • TPL payment/denial information

All claims with a third party denial **must** be submitted on paper with a copy of the third party denial attached. Claims with a third party denial **cannot** be submitted electronically.

Providers must submit legible copies of third party denials when billing Medicaid for services denied by the third party. For claims with dates of service over one year to be considered for payment, the denial must be dated by the insurance company and the claim must be submitted within 120 days of third party denial.

NOTE:

Be sure to indicate on the claim form that it denied for TPL. The table above lists, by claim type and block number, the fields that must be filled out to submit a claim that denied for TPL.

5.2 Completing the CMS-1500 Claim Form

This section describes how to complete the CMS-1500 claim form for submission to HP. For a list of providers who bill for services using the CMS-1500 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use by all providers who bill using this claim form. For program-specific billing information, please refer to the chapter in Part II that corresponds to your provider type.

CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500/837 Professional claims in approved formats. The 837 Professional transaction allows providers to bill up to 50 details per Professional (837 transaction) claim type.

Providers can obtain Provider Electronic Solutions software from HP free of charge. Providers may also utilize Medicaid's Interactive Web Portal. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development

requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

CMS-1500 Claims Form Paper Billing

Providers may obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard CMS format using red dropout ink.

Claims must contain the billing provider's complete name, address, and NPI.

Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number – NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Payee's 10-digit NPI
- Rendering (performing) provider's 10-digit NPI (on each line item)

A claim lacking any of the critical claim information cannot be processed. Also, each claim form must have a provider signature, initials, a stamped signature, or have an agreement on file with HP to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

Guidance Regarding NDC's on the CMS-1500 Form

Effective August 2008, Alabama Medicaid mandated that the National Drug Code (NDC) number be included on the CMS-1500 claim form for the Top 20 physician administered drugs as defined by CMS. Effective October 1, 2010, the NDC number will be mandatory on **ALL** physician-administered drugs in the following ranges: J0000-J9999, S0000-S9999 and Q0000-Q9999. Refer to Appendix H for more information. Medicaid requires that each submitted NDC contain 11-digits (no dashes or spaces). The first 5-digits identify the labeler code of the manufacturer of the drug. The next 4-digits identify the specific strength, dosage form, and formulation of that drug. The last 2-digits identify the package size of the drug.

There may be some instances when an NDC does not contain all eleven digits on the product's container. In the following instances, the correct format for submission of the NDC in Item Number 24A is given:

- xxxx-xxxx-xx; in this case a zero (0) would need to be added in front of the first set of numbers.

  Result: 0xxxxxxxxxx.

- xxxxx-xxx-xx: in this case a zero (0) would need to be added in front of the second set of numbers.

  Result: xxxxx0xxxxx.

- xxxxx-xxxx-x: in this case a zero (0) would need to be added in front of the third set of numbers.

  Result: xxxxxxxxx0x.

Please refer to the Food and Drug Administration (FDA) website below for more information regarding the National Drug Code, http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

For additional questions regarding physician administered drugs, please contact Pharmacy Services at (334) 242-5050.

5.2.1 CMS-1500 Blank Claim Form

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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 F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. 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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES YES 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.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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. EPSDT 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 SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd 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. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

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 1500 (02-12)

SAMPLE

5.2.2 CMS-1500 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the CMS-1500 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

Block No.	*Description*	*Guidelines*
1a	Insured's ID Number	Enter the patient's 13-digit recipient number (12 digits plus the check digit) from the Medicaid identification card and/or eligibility verification response. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
2	Patient's name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID number you entered in Block 1.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
3	Patient's date of birth Patient's sex	Enter the month, day, and year (MM/DD/YY) the recipient was born. Indicate the recipient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (city, state, and ZIP code).
9	Other insured's name (Last name, first name and middle initial)	Enter all pertinent information (9, 9a and 9d) if the recipient has other health insurance coverage. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid.**
9a	Other Insured's Policy or Group Number	Enter the Recipient's other insurance policy or group Number.
9d	Insurance Plan or Program Name	Name of insurance plan or program.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."

Added: 17a Secondary ID – Enter the secondary…**multiple service locations.**

Block No.	***Description***	***Guidelines***
10d	Claim Codes	Enter the appropriate condition code allowed by NUCC. - Valid values include: AA – Abortion performed due to rape AB – Abortion performed due to incest AC – Abortion performed due to serious fetal genetic defect, deformity, or abnormality AD – Abortion performed due to life endangering physical condition caused by, rising from or exacerbated by the pregnancy Itself AE – Abortion performed due to physical health of mother that is not life endangering AF – Abortion performed due to emotional/psychological health of mother AG – Abortion performed due to social or economic Reasons AH – Elective Abortion AI - Sterilization
17	Name of referring physician or other source	Enter one of the following, if applicable: • The name of the referring Patient 1st provider • The EPSDT referring provider if the services are the result of an EPSDT screening • The referring lock-in physician if the eligibility verification response indicates the recipient has Lock-In status Please refer to Section 3.3, Understanding the Eligibility Response, for information on Lock-in or as they relate to recipient eligibility Appendix A, EPSDT, provides referral instructions for EPSDT.
17a	Secondary ID	Enter the secondary identifier for the referring provider in this field. The secondary identifier should be the legacy Medicaid provider number of the provider which rendered the service. **This is an optional field, but is required for providers with multiple service locations.**
17B	Referring NPI number	A referring NPI should only be included for lock-in, Patient 1st, EPSDT or anesthesia referrals.
19	Additional Claim Information	Identifies additional information about the patient's condition on the claim. Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Recouped claim (MM/DD/YY) The substitute provider's name may also be indicated here.
21	Diagnosis or nature of illness or injury and ICD Ind.	A. - L. Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields. Enter ICD indicator for diagnosis codes entered in fields 21A – 21L. • Enter "9" for ICD-9 • Enter "0" for ICD-10 May not submit both ICD versions together on the same claim. **Providers should not submit ICD-10 codes until CMS mandate date.**

Block No.	Description	Guidelines
23	Prior Authorization Number	For prior authorization requests approved by Medicaid, the prior authorization number will be automatically entered into the claims system by Medicaid's contractor. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type. **Do not use for any other number. Leave blank if this does not apply.**
24a	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If identical services (and charges) are performed on the same day, enter the same date of service in both "from" and "to" spaces, and enter the units perform in Block 24g. **Exception**: Provider visits to residents in nursing facilities must be billed showing one visit per line. If entering NDC information, enter N4 qualifier in the first two positions, left justified, followed immediately by the 11 character NDC number (no hyphens).
24b	Place of service (POS)	Enter a valid place of service (POS) code for each procedure. For program-specific POS values, refer to the chapter in Part II that corresponds to your provider or program type.
24c	EMG	This field is used to indicate certain co-payment exemptions: • Enter an "A" for Native American Indian with an active user letter • Enter an "E" for certified emergency • Enter a "P" for pregnancy Do not enter Y or N.
24d	Procedures, Services, or Supplies CPT/HCPCS and MODIFIER	Enter the appropriate five-digit procedure code (and two-digit modifier, as applicable) for each procedure or service billed. Use the current CPT-4 book as a reference. Note: Up to 4 modifiers can be entered per procedure code.
24e	Diagnosis Pointer	Enter the line item reference (A - L) for each service or procedure as it relates to the primary ICD-9 code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis to which the procedure is related must be the one identified. Up to 4 characters can be entered in this block per procedure code
24f	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24g	Days or Units	Enter the appropriate number of units. Be sure that span-billed visits equal the units in this block. Use whole numbers only.
24h	EPSDT Family Plan	Enter one of the following values, if applicable: • "1" if the procedure billed is a result of an EPSDT referral • "2" if the procedure is related to Family Planning • "3" if the procedure is a Patient 1st referral • "4" if the procedure is EPSDT and Patient 1st referral

Block No.	***Description***	***Guidelines***
24I	ID Qual	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. This will only be used for providers that are not required to obtain an NPI. These providers should use the following identifier in 24I: ID which identifies the number being used as a Medicaid provider number. Should a provider need to use a taxonomy code on a claim, use the following: ZZ which identifies the number being used is a provider taxonomy code.
24J	Rendering provider ID	The individual provider performing the service is reported in 24J. If not entering an NPI, the number should appear in the shaded area of the field. The NPI number should be entered in the non-shaded area. Secondary ID: Enter the secondary identifier for the performing provider in the shaded area of the field. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
26	Patient account number	This field is optional. Up to 20 alphanumeric characters may be entered in this field. If entered, the number appears on the provider's Remittance Advice (RA) to assist in patient identification.
28	Total charge	Enter the sum of all charges entered in Block 24f lines 1-6.
31	Signature of physician or supplier	After reading the provider certification on the back of the claim form, sign the claim. In lieu of signing the claim form, a signed Medicaid Claims Submission Agreement or the Provider Agreement, must be on file with HP. The statement "Agreement on File" must be entered in this block. The provider or authorized representative must initial the provider's stamped, computer generated, or typed name.
32	Service Facility Location Information	Enter the performing providers name, street address, city, state, zip code, and tax ID.
32a	Rendering Provider NPI	Enter the NPI for the rendering provider performing the service.
32b	Rendering Provider Medicaid ID	Enter the Medicaid ID for the rendering provider performing the service.
33	Billing Provider Info and Phone Number	1st Line: Name of the Payee provider as it appears in the HP system 2nd Line: Address 3rd Line: City, State and Zip Code (include zip+4) 33A: Enter the payee (group) NPI 33B: Enter the two-digit qualifier (G2) identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and the number. (Only for providers who do not qualify to receive an NPI).

5.3 Completing the UB-04 Claim Form

This section describes how to complete the UB-04 claim form for submission to HP. For a list of providers who bill for services using the UB-04 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use by all providers who bill using this claim form. For program-specific billing information, please refer to the chapter that corresponds to your provider type.

UB-04 Electronic Billing

Electronic billers must submit UB-04/837 Institutional claims in approved formats. The 837 Institutional transaction allows providers to bill up to 999 details per Institutional (837 Institutional transaction) claim type. Providers can obtain Provider Electronic Solutions software from HP free of charge. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

UB-04 Claims Form Paper Billing

HP does not supply the UB-04 claim form. Providers may obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard UB-04 format using red dropout ink.

Claims must contain the billing provider's complete name, address, and NPI. Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number– NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Provider's 10-digit NPI

A claim lacking any of the critical claim information cannot be processed.

NOTE:
Multiple page claims are not accepted for the paper UB-04s.

Guidance Regarding NDC's on the UB-04 Form

Effective September 2008, Alabama Medicaid mandated that the National Drug Code (NDC) number be included on the UB-04 claim form for the Top 20 physician administered drugs as defined by CMS. Effective October 1, 2010, the NDC number will be mandatory on **ALL** physician-administered drugs in the following ranges: J0000-J9999, S0000-S9999 and Q0000-Q9999. Refer to Appendix H for more information. Alabama Medicaid would like to clarify the required format for the NDC number that is submitted on this claim form. Medicaid requires that each submitted NDC contain 11-digits (no dashes or spaces). The first 5-digits identify the labeler code of the manufacturer of the drug. The next 4-digits identify the specific strength, dosage form, and formulation of that drug. The last 2-digits identify the package size of the drug.

There may be some instances when an NDC does not contain all eleven digits on the product's container. In the following instances, the correct format for submission of the NDC in Form Locator 43 (Description) is given:

- xxxx-xxxx-xx; in this case a zero (0) would need to be added in front of the first set of numbers.

  Result: 0xxxxxxxxxx.

- xxxxx-xxx-xx: in this case a zero (0) would need to be added in front of the second set of numbers.

  Result: xxxxx0xxxxx.

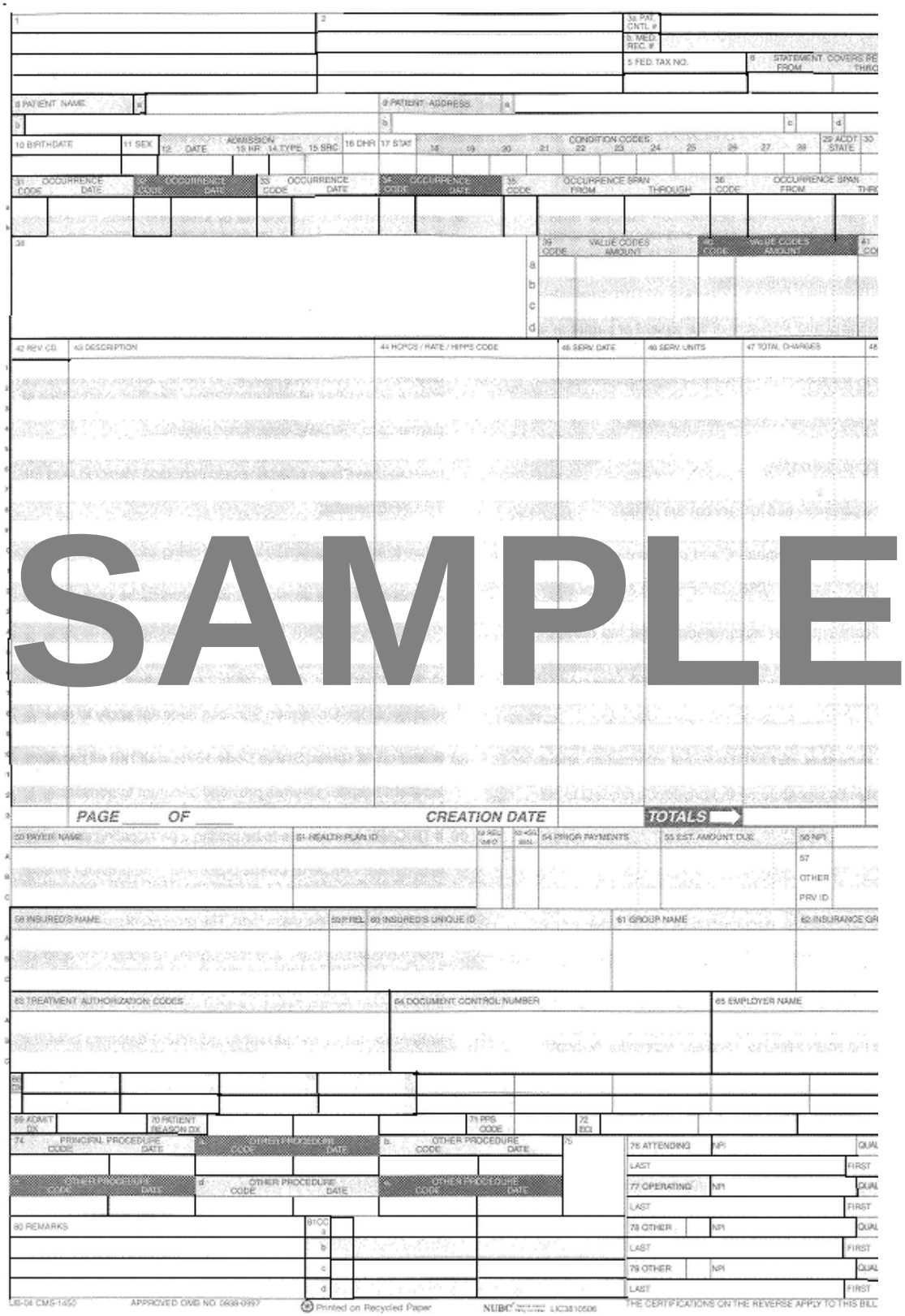
- xxxxx-xxxx-x: in this case a zero (0) would need to be added in front of the third set of numbers.

  Result: xxxxxxxxx0x.

Please refer to the Food and Drug Administration (FDA) website below for more information regarding the National Drug Code, http://www.fda.gov/cder/ndc/index.htm

For additional questions regarding the CMS list of Top 20 physician administered drugs, please contact Pharmacy Services at (334) 242-5050.

5.3.1 UB-04 Blank Claim Form



5.4 UB-04 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the UB-04 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

Block No.	***Description***	***Guidelines***
1	Provider name, address, and telephone number	Enter the provider name, street address, city, state, ZIP code, and telephone number of the service location.
2	Pay to name/address	Required when the pay-to name and address information is different from the billing information in block 1. If used, providers must include, name, address, city, state, and zip.
3A 3B	Patient control number	**Optional**: Enter patient's unique number assigned by the provider to facilitate retrieval of individual's account of services containing the financial billing records. **3B**: Enter the patient's medical record number assigned to the hospital. This number will be referenced on the provider's Remittance Advice for patient identification. Up to twenty-four numeric characters may be entered in this field. .

Block No.	***Description***	***Guidelines***
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Non-patient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice 831 Ambulatory Surgical Center	Enter the four-digit type of bill (TOB) code: **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care 3 Home Health Agency 7 Clinic (RHC, FQHC) *** see note** 8 Special Facility **** see note** **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim ***Clinic requires one of the following as the 2nd Digit – Bill Classification:** 1 Rural Health 2 Hospital-Based or Independent Renal Dialysis Center 3 Free-Standing 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facility (CORF) 6-8 Reserved for National Assignment 9 Other ****Special Facility requires one of the following as the 2nd Digit – Bill Classification:** 1 Hospice (non-hospital-based) 2 Hospice (hospital-based) 3 Ambulatory Surgical Center 4 Free-Standing Birthing Center 5 Critical Access Hospital 6 Residential Facility 7-8 Reserved for national assignment 9 Other
6	Statement covers period	Enter the beginning and ending dates of service billed. For inpatient hospital claims, these are usually the date of admission and discharge.

Block No.	***Description***	***Guidelines***
8	Patient's Name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you entered in Block 60.** If a recipient has two initials instead of a first name, enter the first initial along with a space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
12	Admission Date/Start Date of Care	Enter the total days represented on this claim that are not covered. This is not required for outpatient claims. Enter numerically the date (MM/DD/YY) of admission for inpatient claims; date of service for outpatient claims; or start of care (SOC) for home health claims.
13	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for outpatients (TOB 141) or home health claims (TOB 331).
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 20) 5 Trauma Center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available 6 Transfer from another health care facility
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.

Block No.	***Description***	***Guidelines***
17	Patient discharge status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. Refer to the UB-04 Billing Manual for the valid patient status codes. If status code 30, the total days in blocks 7 and 8 should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
18-28	Condition Codes	Used to indicate EPSDT-Referrals, Family Planning Services, and Co-payment exemptions. A1 Denotes services rendered as the result of an EPSDT screening. Block 78 must also contain the screening 10-digit NPI number. A4 Denotes services rendered as the result of family planning and will exempt the claim from copay. AJ Denotes services rendered for Native American Indian with an active user letter and will exempt the claim from copay.
29	Accident State	REQUIRED ONLY IF AUTO ACCIDENT: Indicate two-digit state abbreviation where the accident occurred.
31-34	Occurrence Codes	Accident related occurrence codes are required for diagnoses between 80000-9949.
39-41	Value Codes and Amounts	Enter the appropriate value code and amount according to the following: 73 Denotes the Medicare Paid Amount 74 Denotes the Medicare Allowed Amount 75 Denotes the Sequestration Reduction 80 Denotes the Covered Days 81 Denotes the Non-Covered Days 82 Denotes the Co-Insurance Days 83 Lifetime Reserve Days A1 Denotes the Medicare Deductible Amount A2 Denotes the Medicare Co-Insurance Amount A7 Medicare Copay
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed. Revenue 001 (total) must appear on each claim. If entering NDC information, enter N4 qualifier in the first two positions, left justified, followed immediately by the 11 character NDC number (no hyphens).
44	HCPCS/Rates	Inpatient Enter the accommodation rate per day. Home Health Home Health agencies must have the appropriate HCPCS procedure code. Outpatient Outpatient claims must have the appropriate HCPCS, procedure code, and NDC. The UB-04 claim form is limited to 23 detail charges.

Added: A7 Medicare Copay

Block No.	***Description***	***Guidelines***
45	Service date	Outpatient: Enter the date of service that the outpatient procedure was performed. Nursing Homes: Enter the beginning date of service for the revenue code being billed. Span Billing: When filing for services such as therapies, home health visits, dialysis, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator (FL) 6 (statement covers period). In FL 45, the service date should be the first date in the statement covers period. The number of units should match the number of services reflected in the medical record.
46	Units of service	Enter total number of units of service for outpatient and inpatient services. For inpatient claims, this will be same as covered plus non-covered days.
47	Total charges	Enter the total charges for each service provided.
48	Non-covered charges	Enter the portion of the total that is non-covered for each line item.
50	Payer	Enter the name identifying each payer organization from which the provider might accept some payment for the charges.
56	NPI Number	Enter the 10- digit NPI Number
58	Insured's name	Enter the insured's name.
60	Insurance identification number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response and the policy numbers for any other insurance on file. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
61	Insured group's name	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	Enter the group number of the other health insurance.
66	ICD Version Indicator	The qualifier denotes the version of the ICD reported. 9=Ninth Revision 0=Tenth Revision.
67	Principal diagnosis code Present on admission indicator	Enter the ICD-9 diagnosis code for the principal diagnosis to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field. Enter the present on admission (POA) indicator in shaded part of the field. This indicator is required for certain diagnosis codes and only on inpatient claims. Valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at the time of inpatient admission. U – Documentation insufficient to determine if condition was present at the time of inpatient admission. W – Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time if inpatient admission.

Block No.	***Description***	***Guidelines***
67A-67Q	Other diagnosis codes Present on admission indicator	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5) for each additional diagnosis. Do not use decimal points in the diagnosis code field. Enter one diagnosis per block. Enter the present on admission (POA) indicator in the shaded part of the field. This indicator is required for certain diagnosis codes and only on inpatient claims.
69	Admitting diagnosis	**For Inpatient Claims**: Enter the admitting ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.
70	Patient Reason DX	**For Outpatient claims only**- Enter the diagnosis for reason the recipient came in for treatment. Up to 3 patient reason diagnosis codes may be entered into this field. **NOTE:** This diagnosis is not always the same as the primary diagnosis.
73	Medicaid emergency/accident indicator	Enter an "H" to indicate that the service was rendered as a result of a home accident or treatment due to disease. Enter an "E" to indicate a certified emergency. A certified emergency ER claim must be certified by the attending physician. Both values may be entered, as applicable.
74a-74e	Principal and other procedure codes and dates	For inpatient hospital claims only, enter the ICD-9 procedure code for each surgical procedure and the date performed. Up to 5 surgical procedure codes and dates may be entered into this field.
76	Attending Physician ID	Enter the attending physician's NPI number and the appropriate qualifier "0B" followed by the physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
77	Operating physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Block 74, enter the surgeon's NPI number and the appropriate qualifier "0B" followed by the surgeon's license number.
78	Other physician ID	Enter the referring physician's NPI number followed by the appropriate qualifier "DN" for the following types of referrals: • EPSDT referrals • Patient 1st referrals • Lock-in Physician referrals If not applicable, leave blank
80	Remarks	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date

Added: **NOTE**

NOTE:

When a recipient is enrolled in a Medicare Advantage Plan and Medicaid has not paid a monthly capitation payment, institutional providers must use the UB-04 claim form when billing Medicaid for Medicare Advantage plan deductibles, coinsurances, or co-pays. These claims will be processed by Medicaid in the same manner as a Medicare paid claim. Report Medicare Advantage deductibles, coinsurances, and co-pays using the appropriate Medicare value code listed in the instructions for fields 39-41 of this section.

This section describes how to complete the 2006 ADA Dental form for submission to HP. For a list of providers who bill for services using the ADA Dental form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use for all providers who bill using this claim form; for program-specific billing information, please refer to Chapter 13, Dental.

Only version 2006 ADA Dental form is acceptable. If you experience problems with HP processing your forms, contact HP for resolution.

ADA Dental Electronic Billing

Electronic billers must submit ADA Dental claims in approved formats. Providers may bill up to 50 details per dental (837 Dental transaction) claim type.

Providers can obtain Provider Electronic Solutions software from HP free of charge. Providers may also use Medicaid's Interactive Web Portal. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

ADA Dental Claim Form Paper Billing

HP does not supply the ADA Dental claim form. Providers may obtain copies of the claim form from a printer of their choice.

Claims must contain the billing provider's complete name, address, and NPI. Critical claim information includes:

- Recipient's first and last name as it appears when verifying eligibility. NOTE: Recipient's Medicaid cards can have the name spelled differently that what is in our system.
- Recipient's 13-digit Medicaid number– NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Provider's 10-digit NPI

A claim without the above information cannot be processed. Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with HP to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

NOTE:

Because HP uses a new scanning process, **do not use a blue pen to complete paper claims.** Do not circle, underline, write notes or highlight any information on the claim. **Send original claim forms only;** do not send copies.

Providers should submit typewritten or computer-generated paper claims whenever possible to speed up the data entry process. Keep in mind the following guidelines:

- Make sure typed information does not fall outside the specific boxes.
- Change printer ribbons often, since claims with print too light to be scanned will be returned.

ADA Dental Blank Claim Form

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. E[illegible]

PATIENT INFORMATION

18. Relationship to Policy[illegible]/Subscriber in #12 Above ☐ Self ☐ [illegible] ☐ Dependent Child ☐ [illegible]
19. [illegible]ent Status ☐ FTS ☐ PTS
20. Name (Last, First, Mi[illegible] Initial, [illegible]uffix), Address, City, State, [illegible]
21. Da[illegible] Birth (M[illegible]D/CCYY)
22. G[illegible]er ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Proc[illegible]de	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH [illegible]RMATION

34. (Place an 'X' on e[illegible]

Permanent																Primary									
[illegible]	2	3	[illegible]	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	[illegible]	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treat[illegible] and associated fees. I agree to be responsible for all charges for dental services and materia[illegible] not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) –
52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number ( ) –
58. Additional Provider ID

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

SAMPLE

5.4.1 ADA Dental Filing Instructions

The instructions describe information that is required to be entered in each of the block numbers on the ADA Dental Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
3	Company/Plan Name, Address, City State, Zip Code	For Medicaid Claims enter: HP, P.O.Box 244032, Montgomery, AL 36124-4032
4-11	Other Coverage *[These blocks are only required if patient has other insurance*].	4. Other Dental or Medical Coverage? Check the applicable box 5. Name of Policyholder/subscriber in #4. Enter other insured's name (Last, First, Middle Initial, Suffix) 8. Policy Holder/Subscriber Identifier (SSN or ID#) Enter the Other Insurance Policy Number 9. Plan/Group Number Enter the plan/group number 10. Relationship to Insured Check the applicable box 11. Other insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
12	Policyholder/subscriber name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code [*Medicaid Recipient Information]*	Enter the Medicaid recipient's name as Last, First. Enter the name EXACTLY as it is given to you as a result of the eligibility verification transaction. Please note the name on the claim must match the information on the HP system for the Medicaid number**.** If the recipient has two initials instead of a first name, enter the first initial with a space, then the second initial without periods. If a recipient's name contains an apostrophe, enter the first name including the apostrophe. Examples: For recipient A. B. Doe, enter Doe, A B without punctuation. For recipient D'Andre Doe, enter Doe, D'Andre with an apostrophe and no spaces.
15	Subscriber Identifier (SSN or ID#)	Enter the recipient's 13-digit Medicaid Number (RID) from the Medicaid eligibility verification response. For instructions on performing eligibility verification transaction, please refer to Chapter 3 of the provider billing manual, Verifying Recipient Eligibility. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
24	Procedure Date (MM/DD/CCYY)	Enter numerically (MM/DD/CCYY) the date of service for each procedure provided.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
25	Area of the Oral Cavity	If applicable, enter the Oral Cavity Designation Code associated with the procedure being performed on a specific tooth. 00 —Full Mouth 01 —Upper Arch 02 —Lower Arch 09 —Other Area of Oral Cavity 10 —Upper Right Quadrant 20 —Upper Left Quadrant 30 —Lower Left Quadrant 40 —Lower Right Quadrant L —Left R—Right There are few procedures that require an oral cavity designation code. Some of these include but are not limited to D4341, D4355, D4910, D7970 and D7971.
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number for the permanent teeth (01-32) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. Enter AS – TS for children and 51-82 for adults with supernumerary teeth regardless of location in maxilla or mandible. Permanent teeth must be two-digit fields. For tooth number 1-9, you must indicate 01-09.
28	Tooth Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL). The block is left blank for exams, X-rays, fluoride and crowns. M – Mesial F – Facial; Labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal B —Buccal; Labial
29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure.
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
35	Remarks	The only information that should be written in this section is “TPL Denial Attached” and the date of the third party denial (other insurance) Make sure the EOB denial statement is attached. NO OTHER comments should be written in this section.
38	Place of Treatment	Check applicable box. ***Use the Hospital box to indicate outpatient hospital or inpatient hospital.
45-47	Treatment Resulting from	If applicable, check applicable box. If auto accident, provide date of accident (mm/dd/ccyy) and the two-digit state abbreviation of the state in which the accident happened.
48	Billing Dentist or Dental Entity (Name, Address, City, State, Zip Code)	Enter the billing provider's name, street address, city, state, and zip code.
49	NPI	Enter the Organizational/**Billing** NPI number.
52A	Additional Provider ID	Enter the **billing** provider’s Alabama Medicaid provider number.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
53	Treating Dentist and Treatment Location Information [provider's signature]	Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with HP to omit signature requirement. Refer to the Alabama Medicaid Provider Manual, Chapter 5 section 5.1.7, Provider Signatures, for appropriate signature requirements.
54	NPI	Enter the NPI of the actual dentist performing the service, i.e. the **treating** (rendering or performing) NPI number.
56A	Provider Specialty Code	Enter the taxonomy code of the **treating** (rendering or performing) dentist.
58	Additional Provider ID	Enter the **treating** (rendering or performing) provider's Alabama Medicaid provider number.

5.5 Completing the Pharmacy Claim Form

This section describes how to complete the pharmacy claim form for submission to HP. For a list of providers who bill for services using the pharmacy claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use for all providers who bill using this claim form; for program-specific billing information, please refer to Chapter 27, Pharmacy.

Pharmacy Electronic Billing

Electronic billers must submit pharmacy claims in approved formats. Providers can obtain Provider Electronic Solutions software from HP free of charge. Providers may also use Medicaid's Interactive Web Portal. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

Pharmacy Paper Billing

Medicaid pharmacy claim forms may be purchased through HP. Providers may also obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed using red dropout ink.

Claims must contain the billing provider's complete name, address, and NPI.
Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number– NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Provider's 10-digit NPI
- Rx number (cannot be more than 7 digits)

A claim without the above information cannot be processed. Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with HP to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.5.1 Pharmacy Blank Claim Form

ALABAMA MEDICAID PHARMACY CLAIM XIX-DC-10-93

RECIPIENT NAME		ORIG RX DATE	TPL CARRIER INFORMATION	PHYSICIAN LICENSE NO.
MEDICAID NUMBER		1	CARRIER CODE/ CO. NAME	
		2	POLICY NO.	
		3		

SUBMIT TO
HP
P.O. BOX 244032
MONTGOMERY, ALABAMA 36124-4032

PHARMACY PROVIDER NO./NAME	DATE DISPENSED
PHARMACY ADDRESS	

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE CLAIM IS UNPAID. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PHARMACIST

	COPAY	PRIOR AUTHORIZATION NO.
1		
2		
3		

SAMPLE

	LABELER NO.	DRUG CODE PRODUCT CODE		QUANTITY	DAYS SUPPLY	REFILL(S) NO.	U.C. AND CUSTOMARY CENTS
1							
2							
3							
						TOTAL	

	DOLLARS	CENTS	REASON CODE
1			
2			
3			

5.5.2 Pharmacy Filing Instructions

The instructions describe information that must be entered in each of the fields on the Pharmacy Form. **Fields not referenced in the table may be left blank. They are not required for claims processing by HP.**

Field Description	***Guidelines***
Recipient name and Medicaid number	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you entered in the Medicaid Number block.** Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. For recipients who have two initials for their first name, enter the first initial with a long space, then the second initial and no periods. For example, A. B. Doe would be filed as Doe A B. For recipients who have an apostrophe in their first name, enter the first letter of the first name and the apostrophe. For example, D'Andre Doe would be filed as Doe D'Andre.
Orig. Rx Date	Enter the date of the original prescription
TPL Carrier Information	Complete this portion only if the recipient has other insurance. Carrier code/Co. name — The insurance company name or carrier code may be obtained from Appendix K of this manual or by calling the HP Provider Assistance Center at 1 (800) 688-7989. Policy no. — The insured's insurance policy number
Physician's license no.	Enter the physician's state license number or National Provider Identifier (NPI), which should display on the prescription
Pharmacy license no./name	Enter the 10-digit NPI and name
Date dispensed	Enter the date the prescription is dispensed to the recipient
Pharmacy address	Enter the pharmacy street address, city, state, and zip code.
Pharmacist	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
Received by	Obtain the recipient's signature or enter "Signature on file" if the provider has the recipient's signature on file (such as a sign in sheet) as verification that the recipient was present on the date of service for which the provider seeks payment.
Copay	Enter "P" if the recipient is pregnant to indicate copay exemptions. Enter "A" if the recipient is a Native American Indian with an active user letter to indicate copay exemptions.
Prior Authorization	For prior authorization requests approved by Medicaid, the prior authorization number will be automatically entered into the claims system by Medicaid's contractor. Enter the ten-digit prior authorization number (0000999527) only when using the 72 hour emergency supply prior authorization number.
Rx number	Enter the prescription number
Drug code	Enter the NDC code

Field Description	*Guidelines*
B/N	Brand Necessary. This field is also known as the "Dispense as Written (DAW)" or Product Selection field. Valid values are as follows: **Ø=No Product Selection Indicated-**This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed. **1=Substitution Not Allowed by Prescriber**-This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written. **2=Substitution Allowed-Patient Requested Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. *(Not permitted by Alabama Medicaid)* **3=Substitution Allowed-Pharmacist Selected Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. **4=Substitution Allowed-Generic Drug Not in Stock**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace. **5=Substitution Allowed-Brand Drug Dispensed as a Generic**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity. **6=Override** *(Not permitted by Alabama Medicaid)* **7=Substitution Not Allowed-Brand Drug Mandated by Law**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace. **8=Substitution Allowed-Generic Drug Not Available in Marketplace**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. **9=Substitution Allowed- Plan Requests Brand Dispensed –** This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic is permitted, but the plan's formulary requests the brand product to be dispensed. **Note: These "Dispense as Written" values are required for the DAW field for electronic pharmacy claims. For more information on DAW, please visit Chapter 27 of the Billing Manual.**

Field Description	***Guidelines***
Quantity	Enter the quantity or number of units dispensed. **Please note there are five (5) spaces on the claim form for quantity. All five spaces must be completed.** There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045. **If a product is supplied in fractional units (for instance, a 3.5gm tube of ointment), Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed. In this example, the quantity billed should be 0003.5**
Days supply	Enter the amount of time the medication dispensed should last. The days supply is limited to 34.
Refills	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.
Usual and customary	Enter the amount (dollars and cents) of your customary charge.
TPL payment/denial information	These fields are completed only if the recipient has other insurance. If the other insurance makes a payment, it should be indicated in the dollars/cents field. The appropriate NCPDP other coverage reason code must also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the NCPDP other coverage reason code must be included.

5.6 Completing the Medical Medicaid/Medicare Related Claim Form

Medical and inpatient institutional claims filed to Medicare (at BCBS Alabama) crossover directly to Medicaid weekly for claims processing. Providers should wait **at least 21 days** from the date of the Medicare Explanation of Medical Benefits (EOMB) before electronically filing a medical or inpatient crossover claim to HP Outpatient institutional claims, out-of-state Medicare claims, and those medical and inpatient claims 21 days old or older must be submitted electronically to HP using the appropriate Medicare/Medicaid-related Claim Form.

Electronic billers must submit crossover claims in approved formats. *Provider Electronic Solutions* software allows crossover billing via the 837 Institutional transactions and is available from HP free of charge for providers. Providers may also use Medicaid's Interactive Web Portal. Specifications are also available to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1 (800) 456-1242.

5.6.1 Medical Medicaid/Medicare-related Blank Claim Form

Do not write in this space. Do not use red ink to complete this form.

MEDICAL MEDICAID/MEDICARE RELATED CLAIM

1. RECIPIENT INFORMATION

a. Medicaid ID	
b. First Name	
c. Last Name	
d. Med. Rec. #	
e. Patient Acct. # (Optional)	

2. OTHER INSURANCE INFORMATION

a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no	
b. If other insurance rejected, attach rejection to completed claim and mail to HP and enter date TPL was denied here (MM/DD/YY).	
c. If other insurance paid, attach the completed Medicaid Other Insurance Attachment form (ALTPL01) and mail to HP.	

3. DIAGNOSIS CODES

A._____ B._____ C._____ D._____ E._____ F._____

G._____ H._____ I._____ J._____ K._____ L._____

4. VERSION: 9=ICD-9, 0=ICD-10	

5. DETAIL OF SERVICES PROVIDED

	a. DATES OF SERVICE		b. POS	c. NDC	e. UNIT	f. MOD	g. DIAG PTR	h. CHARGES	MEDICARE			
	FROM	THRU		d. PROCEDURE CODE					i. ALLOWED	j. COINS.	k. DEDUCTIBLE	l. PAID
1												
2												
3												
4												
5												
6												
7												
8												
9												
							6. TOTALS	a.	b.	c.	d.	e.

SAMPLE

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment is less than 120 days old.

7. Billing Provider Name	a.			
7. Billing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID
8. Performing Provider Name	a.			
8. Performing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

5.6.2 Medical Medicaid/Medicare-related Claim Filing Instructions

The Medical Medicaid/Medicare-related claim form may be obtained from HP at no charge when an Administrative Review is being requested. For scanning purposes, only those forms printed with red dropout ink will be accepted.

NOTE:

When a recipient is enrolled in a Medicare Advantage plan and Medicaid has not paid a monthly capitation payment, professional service providers must use the Medical Medicaid/Medicare-related claim form when billing Medicaid for Medicare Advantage plan deductibles, coinsurances, or co-pays. These claims will be processed by Medicaid in the same manner as a Medicare paid claim. Medicare Advantage deductibles, coinsurance, and co-pays should be reported on the crossover claim in the appropriate Medicare field.

Added: When a recipient…payment, professional service

Deleted: ~~When providers file…Plan's assigned number~~

Deleted: ~~in the Medicare Coinsurance field~~

Refer to Appendix L, AVRS Quick Reference Guide, for information on checking claim status.

This form is required for all medical Medicare-related claims in lieu of the CMS-1500 claim form and the Medicare EOMB. **The only required attachments are for third party denials or TPL attachment form if third party paid.** The Medicare EOMB is no longer required.

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Block Number	*Field Description*	*Guidelines*
1	Recipient Information	a. Enter the recipient's 13-digit RID number. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. b. Enter the recipient's first name. c. Enter the recipient's last name. d. Enter the recipient's medical record number. (Optional) e. Enter recipient's patient account number (to be referenced on the Remittance Advice (RA) for patient identification). Up to 20 characters may be entered into this field. (Optional)
2	Other Insurance Information	a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no b. If other insurance rejected attach rejection to completed claim and enter date TPL was denied (MM/DD/YY) c. If other insurance paid attach TPL form (ALTPLO1) to the claim.
3	Diagnosis Codes	A. - L. Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.
4	Version	Enter 9 for ICD-9 diagnosis codes

Block Number	***Field Description***	***Guidelines***
5	Detail of Services Provided	a. Enter the from and through dates in MMDDYY format. b. Enter the two-digit place of service as filed to Medicare. c. Enter identifier N4 and the National Drug Code (NDC) for the procedure, if required. d. Enter the five-digit procedure code. e. Enter the number of units of service. f. Enter the modifiers for the procedure code. Enter up to 4 modifiers. g. Enter diagnosis pointer (Ex. Enter A or B) h. Enter the charge for each line item. i. Enter the Medicare allowed amount for each line item. *FQHC, PBRHC, and IRHC should enter the per diem encounter rate established by Medicaid for the facility for each line item. a. Enter the sequestration reduction b. Enter the eRX reduction j. Enter the Medicare coinsurance amount for each line item. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.** k. Enter the amount applied to the Medicare deductible for each line item. l. Enter the Medicare paid amount for each line item *FQHC, PBRHC, and IRHC should enter the Medicare per diem paid amount for each line item.
6	Totals	a. Total for charges. b. Total for allowed amount. c. Total for coinsurance amount. d. Total for deductible amount. e. Total for paid amount.
7	Billing Provider Name	a. Enter the billing/payee provider name.
7	Billing Provider ID	b. NPI: Enter the NPI of the billing/payee provider c. Taxonomy: Enter the taxonomy code of the billing provider (optional) d. Qu: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, use qualifier code “1D”. e. Secondary ID: Enter the secondary identifier for the billing provider ID. The secondary identifier should be the legacy Medicaid provider number. This is an optional field, but is required for providers with multiple service locations.
8	Performing Provider Name	a. Enter the name of the provider which performed the service.

Block Number	Field Description	Guidelines
8	Performing Provider ID	b. NPI: Enter the NPI of the provider which performed the service. c. Taxonomy: Enter the taxonomy code for the provider which performed the service. (Optional) d. Qu: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, use qualifier code "1D". e. Secondary ID: Enter the secondary identifier for the performing provider. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
9	Provider Mailing Address required in block below	Enter the billing address, city, state, and zip code for the rendering (performing) provider.

Effective January 1, 2009, the Institutional Medicaid/Medicare related claim form is no longer accepted. Please refer to instructions on completing the UB-04 claim form to indicate Medicare information.

5.7 Required Attachments

Providers are required to submit attachments for particular services. The table below describes Alabama Medicaid required attachments.

Attachment	Guidelines
Third party denials other than Medicare	Providers must submit legible copies of third party denials when billing Medicaid services denied by a third party.
Third party payment other than Medicare	When a claim must be submitted on paper for an administrative or manual review and a third party payment was made, attach form ALTPL-01 10/12.

NOTE:

All third party denials must be attached with the claim and sent hard copy. Claims with third party denials may not be sent electronically.

NOTE:

When a claim must be submitted on paper for administrative or manual review and third party insurance has made a payment or applied charges to patient responsibility, Form ALTPL-01 10/12 – Medicaid Other Insurance Attachment must be attached with the claim and sent hard copy.

5.7.1 TPL Attachment Forms

Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing.

5.7.1.1 TPL Attachment Blank Form

Do not write in this space. Do not use red ink to complete this form.

MEDICAID
OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a. NPI	**Name**	b.
2. Medicaid ID	a.	**Name**	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1.				
2.				
3.				

4. Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

5.7.2 TPL Attachment Filing Instructions

The instructions describe information that is required to be entered in each of the block numbers on the Medicaid Other Insurance Attachment Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

Block Number	***Field Description***	***Guidelines***
1	Billing Provider ID	a. Enter billing Provider NPI b. Enter billing Provider name
2	Medicaid ID	a. Enter recipient Medicaid ID b. Enter the recipient full name
3	List of Payors	Enter the following information in order of responsibility: a. Health Plan ID b. Payor name and Address c. Policy Number d. Date Paid
4.	TPL payment amounts	Enter the TPL amounts per claim detail. **Note**: For header amount on institutional claims use detail number 0. a. Detail number b. Payor sequence c. Copay amount d. Coinsurance amount e. Deductible amount f. TPL paid amount Note: Sequence 1= Primary, 2= Secondary, 3= Tertiary

5.7.3 Required Consent Forms

Consent forms are no longer required attachments with the claim form. The accompanying claim may be sent electronically however, the actual forms must be sent hard copy to the claims address. These forms are scanned and matched electronically with the related claims before processing.

Consent Form	*Guidelines*
Sterilization consent form	A sterilization consent form is required for tubal ligations and vasectomies.
Hysterectomy consent form	A hysterectomy consent form is required when seeking payment for reasons of medical necessity, and not for purpose of sterilization.
Abortion certification form	An abortion certification and documentation of abortion form are required for abortions. Medicaid will not pay for any abortion or services related to an abortion unless the life of the mother would be endangered if the fetus were carried to term.

5.8 Adjustments

Adjustments may be performed only on claims **paid** in error (for example, overpayments, underpayments, and payments for wrong procedure code, incorrect units, or other errors). The adjustment process allows the system to "take back" or cancel the incorrect payment and reprocess the claim as if it were a new claim. Providers must submit their adjustment requests electronically. For all waiver provider claims adjustment refer to Chapter 107 – Waiver Services.

5.8.1 Online Adjustments

Providers can submit electronic adjustments using the HP Provider Electronic Software or vendor-supplied software designed using specifications received from HP. Through this process, providers can recoup previously paid claims with dates of service up to three years old. Claims within the timely filing limit may be adjusted for correction and resubmitted for accurate payment the same day the electronic adjustment is made.

To submit electronic online adjustments, providers must use accurate information relating to the previously paid claim. The HP Provider Electronic Solutions software or provider's vendor system will require that provider submit a new (837) Professional, Institutional or Dental transaction, with *Original Internal Control Number (ICN)* field populated. This electronic adjustment claim will be assigned a new ICN number with a region of 52.

The adjustment claim will process accordingly, and result in a new (835) electronic Remittance Advice (RA) and the original claim information will appear on the 835 (RA) as a void, if processed within the same check write cycle.

Adjustments appear in the *Adjusted Claims* section of the provider Remittance Advice (RA) and consist of two segments: **Credit** (Repaid at lower amount/denied) and **Debit** (Repaid at higher/same amount). The **Credit** segment lists the amount owed to HP from the original paid claim. This amount will also display in the *Financial Items* section of the RA as a deduction.

The **Debit** segment indicates there is a repayment of an original claim and provides a complete breakdown of corrected information. The paid amount is included in the total paid claims amount.

An Adjustment occasionally results in a denied claim. Denied Adjustments do not display in the *Adjusted Claims* section on the RA; they are listed in the *Denied Claims* section. The amount is withheld from the current explanation of payment and listed in the *Financial Items* section.

Refer to Chapter 6, Receiving Reimbursement, for more information relating to adjustments as described in the RA.

NOTE:

The filing deadline applies to any claim that must be resubmitted due to an adjustment.

5.9 Refunds

If you receive payment for a recipient who is not your patient or are paid more than once for the same service, it is your responsibility to refund the Alabama Medicaid Program.

Provide refunds to the Medicaid Program by using the Check Refund Form (a sample can be found in Appendix E) accompanied by a check for the refund amount. Make the check payable to:

HP – Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Please provide the following information in the appropriate fields on the Check Refund Request exactly as it appears on your Remittance Advice (RA) for each refund you send to HP:

- Provider Name and NPI
- Your check number, check date, check amount
- 13-digit claim number or ICN (from RA)
- Recipient's Medicaid ID number and name (from RA)
- Dates of service
- Date of Medicaid payment
- Date of service being refunded
- Services being refunded
- Amount of refund
- Amount of insurance received, if applicable (third party source other than Medicare)
- Insurance name, address and policy number
- Reason for return (from codes listed on form)
- Signature, date and telephone number

This information will allow your refunds to be processed accurately and efficiently.

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts. **If providers receive duplicate payments from a third party and Medicaid, all duplicate party payments must be refunded within 60 days by**:

- Sending a refund of insurance payment to the Third Party Division, Medicaid; or
- Requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

Providers are responsible for ensuring that Medicaid is reimbursed from any third party payment made to a source other than Medicaid as a result of the provider releasing information to the recipient, the recipient's representative, or a third party.

5.10 Inquiring about Claim and Payment Status

Providers may use any of several options to inquire about claim and payment status:

- Call AVRS Provider Electronic Solutions Software
- Review the Remittance Advice (RA) for the corresponding checkwrite
- Contact the HP Provider Assistance Center at 1(800) 688-7989
- Contact HP Provider Relations in writing at **HP Attn: Provider Relations P.O. Box 241685 Montgomery, AL 36124-1685.**
- Access the Alabama Medicaid Agency Interactive Services Website at https://www.medicaid.alabamaservices.org/ALPortal

Calling AVRS

Please refer to Appendix L, AVRS Quick Reference Guide, for instructions on using AVRS to inquire about claim and payment status.

Contacting the HP Provider Assistance Center

The HP Provider Assistance Center (PAC) is available Monday through Friday, 8:00 a.m. – 5:00 p.m. at 1(800) 688-7989. An assistance center representative can answer your questions about claim status, eligibility, or other claims related issues. **It is recommended that you use AVRS, Provider Electronic Solutions Software or access the Alabama Medicaid Agency Interactive Services website before calling the HP Provider Assistance Center. To ensure the Assistance Center is available to all providers, HP must limit providers to three transactions per telephone call. Through AVRS, however, providers may perform up to ten inquiries, including prior authorization requirements, claim status inquiries, and multiple eligibility verification requests.**

When a provider calls the Provider Assistance Center, the PAC representative logs a "ticket" in the call tracking system, including the NPI, contact name and number, and a description of the problem, question, or issue. If the issue is resolved during the call, the PAC representative records the resolution and closes the ticket. If the issue requires research, the PAC representative records the issue and keeps the ticket in an open status. Other HP and Medicaid personnel can review the open ticket and participate in the resolution of the issue. The ticket stays open in the call tracking system until the issue is resolved. This enables HP to monitor its service to providers.

Contacting HP in Writing

Providers may contact HP in writing to resolve more complex billing issues. This correspondence will be reviewed by HP Provider Relations, which is composed of field representatives who are expert in Medicaid billing policy. HP will respond to written inquiries within seven (7) business days and telephone inquiries by the end of the next business day.

The difference in response time occurs because HP' Provider Assistance Center is fully staffed during regular business hours, and can receive, resolve, or forward all billing and claim-related calls, ensuring they are answered in a timely fashion. Provider Representatives, who provide responses to written requests, travel on a regular basis, providing billing assistance to the Alabama Medicaid provider community. It is therefore recommended that providers contact the Provider Assistance Center to begin the inquiry process, and follow up with written correspondence as the need arises.

Accessing the Alabama Medicaid Agency Interactive Services Website

The Alabama Medicaid Agency Interactive Services secure website gives you the opportunity to view claim status and eligibility verification inquiries and to upload and download standard X12 and NCPDP transactions.

Contact HP Helpdesk if you need a User ID and Password.

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