Florida Medicaid

Provider Reimbursement Handbook, CMS-1500

Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

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October 13, 2008

Dear Medicaid Provider:

Enclosed please find the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, effective July 2008. We added the time limit for submission of a claim to Chapter 1. We also added a new Chapter 3, which contains additional filing requirements, such as prior authorizations, authorization for inpatient hospital admissions, and special forms that must be submitted with claims for certain types of services. Please use this new handbook in place of the advance draft that was posted on the Medicaid fiscal agent's website on May 29, 2008.

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on EDS' Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services

UPDATE LOG
MEDICAID PROVIDER REIMBURSEMENT HANDBOOK
CMS-1500

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web Portal may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE NO.	EFFECTIVE DATE
New Handbook	July 1999
May2001 – Update Pages	May 2001
Errata May2001 Update Page	May 2001
Oct2003 – New Handbook	October 2003
Feb2006—Revised Handbook	February 2006
Jan2007—Replacement Pages	January 2007
Nov2007—Replacement Pages	November 2007
Jul2008—Revised Handbook	July 2008

FLORIDA MEDICAID PROVIDER REIMBURSEMENT HANDBOOK
CMS-1500

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, and who is eligible to receive them.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term "provider" is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.
Recipient	The term "recipient" is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources is included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an “Update No.” and the “Effective Date.”

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

Paragraph with new material.

CHAPTER 1
COMPLETING THE CLAIM FORM

Overview

Introduction

This chapter describes how to complete and submit the CMS-1500 (08/05) claim form for payment from the Florida Medicaid Program through the Medicaid fiscal agent. The CMS-1500 (08/05) claim form is incorporated by reference in 59G-4.001(2), F.A.C.

CMS-1500 claim forms may be ordered from the Medicaid fiscal agent by completing and submitting a claims order. The order form is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Forms. Providers may also obtain forms by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

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Providers Who Bill on the CMS-1500

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This handbook contains the claims processing requirements for Florida Medicaid, including the requirements necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook. The Florida Medicaid Provider General Handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbook is incorporated by reference in 59G-5.020, F.A.C.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, call the Medicaid fiscal agent EDI Help Desk at 866-586-0961 or 800-289-7799, select Option 3.

Providers Who Are Required to Bill on the CMS-1500 Claim Form

The following providers, when billing on a paper claim form, must bill on a CMS-1500 claim form to receive Medicaid reimbursement:

- Advanced Registered Nurse Practitioners
- Ambulance, Land and Air
- Ambulatory Surgical Centers
- Assistive Care Providers
- Audiologists
- Birthing Centers
- Child Health Check-Up Providers
- Children at Risk Targeted Case Management
- Children's Health Services Targeted Case Management
- Chiropractors
- Community Mental Health Services Providers
- County Health Departments
- County Health Department Certified Match
- Dentists (as described below)
- Durable Medical Equipment
- Early Intervention Services
- Federally Qualified Health Centers
- Hearing Aid Specialists
- Home and Community-Based Waiver Services
- Home Health
- Independent Laboratories
- Licensed Midwives
- Medicaid Certified School Match
- Medical Foster Care
- Mental Health Targeted Case Management
- Opticians

Providers Who Bill on the CMS-1500, continued

CMS-1500 Claim Form, continued

- Optometrists
- Physicians
- Physician Assistants
- Podiatrists
- Portable X-ray
- Prescribed Pediatric Extended Care
- Registered Nurse First Assistants
- Rural Health Clinics
- Therapists
- Visual Services
- Wheelchair and Stretcher Vans
- Any other provider whose service-specific Coverage and Limitations Handbook requires the CMS-1500 claim form.

Electronic Claim Submission

The policies in this handbook for completing a paper CMS-1500 claim form are applicable to all claim submissions.

Note: See Electronic Claims Submission in this chapter for additional information.

Dental Services Billed on the CMS-1500 Claim Form

Dental providers must complete a CMS-1500 claim form (08/05) for the following procedure codes:

- Procedure codes listed on the oral and maxillofacial fee schedule, with the exception of radiology and evaluation and management codes. Only dentists enrolled in the Medicaid program as oral surgeons may bill these codes.
- Procedure codes for drugs (injectable medications).
- Procedure codes that require a modifier.

Note: See the Dental Oral and Maxillofacial Surgery fee schedule and the Dental Injectable Medications fee schedule for the procedure codes. The fee schedules are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Click on Public Information for Providers, then on Provider Support, and then on Fee Schedules. The fee schedules are incorporated by reference in 59G-4.002, F.A.C.

Time Limit for Submission of a Claim Form

Timely Claim Submission

Medicaid providers should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline. Copied claims are allowed only for voids, adjustments, and exceptional claims processed through the area Medicaid offices.

Clean Claim

In order for a claim to be paid, it must be a clean claim. Per Rule 59G-1.010 (42), F.A.C., "clean claim" means a claim that:

- Has been completed properly according to Medicaid billing guidelines;
- Is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment; and
- Can be processed and adjudicated without obtaining additional information from the provider or from a third party.

A clean claim includes a claim with errors originating in the claim system. It does not include a claim from a provider who is under investigation for fraud, abuse, or violation of state or federal Medicaid laws, rules, regulations, policies, or directives or a claim under review for medical necessity.

12-Month Filing Limit

A clean claim for services rendered must be received by Medicaid or its fiscal agent no later than 12 months from the date of service.

Out-Of-State Claims

Claims submitted by out-of-state providers must be received by the Medicaid office or its fiscal agent no later than 12 months from the date of service to be considered for payment.

Time Limit for Submission of a Claim Form, continued

Out-Of-State Exemption

Because of differences in Medicaid billing practices between states, out-of-state providers are exempt from the clean claim requirement. Out-of-state providers must however, comply with all other Florida Medicaid claim filing regulations including adherence to claim filing time limits.

If the original claim was filed within 12 months from the date of service but did not pay and it is now beyond 12 months, the provider must mail the claim to the Medicaid office for the area in which the recipient resides, instead of the fiscal agent.

Note: The area Medicaid offices' telephone numbers are available on the Agency for Health Care Administration's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbook is incorporated by reference in 59G-5.020, F.A.C.

Date Received Determined

The date stamped on the claim by any Medicaid office or by the Medicaid fiscal agent is the recorded date of receipt for a paper claim. The fiscal agent date stamps the claim the date that it is received in the mailroom as part of the 13-digit Internal Control Number (ICN) that is assigned to each claim.

The date electronically coded on the provider's electronic transmission by the Medicaid fiscal agent is the recorded date of receipt for an electronically submitted claim.

12-Month Begin Date for RPICCs

The initial date for the 12-month filing limit for Regional Perinatal Intensive Care Centers (RPICC) is the date of discharge from the RPICC program.

Third Party Payer or Insurance Claims

Claims for recipients who have Medicare or other insurance must be submitted to a third party payer prior to sending the claim to Medicaid.

Claims for recipients who have third party insurance, other than Medicare, must be received by Medicaid or the Medicaid fiscal agent no later than 12 months from the date of service or six months from the date of third party insurance payment or denial.

The filing limit for Medicare claims crossing over to Medicaid is the greater of 36 months from the date of service or 12 months from Medicare's adjudication date, whichever is later.

Time Limit for Submission of a Claim Form, continued

Claim Adjustment Requests

All clean claim adjustment requests must be received by the area Medicaid office or its fiscal agent no later than 12 months from the date of the original payment.

Claim Void Requests

The 12-month filing limit does not apply to claim void requests. Claim void requests may be submitted at any time.

Exceptions to the 12-Month Time Limit

Exceptions to the 12-month claim submission time limit may be allowed, if the claim meets one or more of the following conditions:

- New clean claim submitted within six months of the date of the void of original claim payment date,
- Court or hearing decision,
- Delay in recipient eligibility determination by either the Department of Children and Families (DCF) or the Social Security Administration (SSA),
- Medicaid delay in updating the eligibility file,
- Court ordered or statutory action, or
- System error or fiscal agent processing error on a claim that was originally submitted within 12 months from the date of service.

Any claim submitted more than 12 months from the date of service that meets an exception must be sent to the area Medicaid office for processing, not to the fiscal agent. Each of these exceptions is discussed below.

Note: The area Medicaid offices' telephone numbers are available on the Agency for Health Care Administration's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Original Payment Is Voided

When an original Medicaid claim is voided, the provider may submit a new claim and a written request for assistance to the area Medicaid office no later than six months from the void date.

Note: The area Medicaid offices' telephone numbers are available on the Agency for Health Care Administration's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Time Limit for Submission of a Claim Form, continued

Court or Hearing Decision

When a recipient is approved for Medicaid as a result of a fair hearing or court decision, there is no time limit for the submission of a claim.

Delay in Recipient Eligibility Determination

An exception is granted when there is a delay in the determination of an individual's Medicaid eligibility by DCF or SSA. The provider must send in specific documentation to the area Medicaid office no later than 12 months from the date the recipient's eligibility is posted to the Florida Medicaid Management Information System (FMMIS). The claim submission must include:

- A clean claim,
- A copy of the recipient's proof of eligibility, and
- Documentation of the reason for late submission.

Medicaid Delay In Updating Eligibility File

If Medicaid delays updating a recipient's eligibility on FMMIS, an exception may be granted. The provider must submit the related clean claims to the area Medicaid office no later than 12 months from the date the recipient's eligibility file was updated.

Court Ordered or Statutory Action

If the Medicaid office takes corrective actions due to a court order or due to final agency action taken under Chapter 120, Florida Statutes, there is no time limit for claim submission.

System Error

If a clean claim is denied due to a system error, a fiscal agent processing error, or any error that is the fault of Medicaid or the fiscal agent, an exception may be granted if the provider submits another clean claim along with documentation of the denial to the area Medicaid office no later than 12 months from the date of the original denial.

Evaluate the Claim

The provider must evaluate any claim that exceeds the 12-month filing limit and determine if the claim fits any of the conditions for an exception to the 12-month filing limit.

Submit a New Medicaid Claim Form

The provider must complete and submit a new Medicaid claim form that meets the following criteria:

- The new claim must be a clean claim.
- A signed or initialed legible photocopy of the original claim is acceptable.
- All required attachments that were necessary for processing the original claim must be attached to the exception claim.

Corrections can be made to a photocopy of the claim, but the system will not accept claims with correction fluid, whiteout or highlighted areas.

Time Limit for Submission of a Claim Form, continued

Supporting Documentation

The provider must send a letter explaining the circumstances of the request for an exception to the time limit, and attach documents that support the exception request. One or more of the following items must be attached:

- A copy of a hearing decision or court order,
- A copy of the recipient's proof of eligibility, or
- A copy of the remittance voucher that indicates the incorrect denial from Medicaid.

Where to Send Requests

All requests for an exception to the 12-month filing time limit must be sent to the area Medicaid office.

Note: The area Medicaid offices' telephone numbers are available on the Agency for Health Care Administration's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Basic Guidelines for Completing a Claim Form

Ordering the Claim Forms

Providers may order claim forms by completing and submitting a claims order form to the Medicaid fiscal agent. The order form is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Forms. Providers may also obtain the form by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Basic Rules

There are some basic rules to follow before completing the claim form.

- Make sure the CMS-1500 is the right form to use for the claim.
- Use one claim form for each recipient.
- Enter one procedure code per claim line.
- Enter all information in black type or black ink. (The fiscal agent can only process claims with black type or ink.)
- Be sure the information on the form is legible.
- Enter information within the allotted spaces.
- Do not use correction fluid on the claim form; correction tape is acceptable.
- Complete the form using the service-specific Coverage and Limitations Handbook as a reference.
- Follow the instructions found in this handbook for completing the CMS-1500 claim form for Medicaid reimbursement. Some fields are not self-explanatory or have multiple uses, so if you are uncertain as to how to complete an item on the claim form, please refer to this handbook for the most comprehensive and correct instructions. Incorrect entries can result in denied Medicaid claims.

Note: The Florida Medicaid Coverage and Limitations Handbooks are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The handbooks are incorporated by reference in the Medicaid Services Rule Chapter, 59G-4, F.A.C.

Basic Guidelines for Completing a Claim Form, continued

Before Completing the Form

Before filling out the claim form, answer the following questions:

- Was the recipient eligible for Medicaid on the date of service?
- Has the recipient's eligibility been verified?
- Was MediPass or HMO authorization obtained, if applicable?
- Was the service or item covered by Medicaid?
- Was service authorization obtained, if applicable?
- Was prior authorization obtained, if applicable?
- Has a claim been filed and a response received for all the recipient's other insurance?
- Was the procedure within the service limitations?
- Does this claim require any medical documentation or attachment?

If all of the above information is not available, review the instructions in this handbook. If the response to all of the above, applicable questions is "yes," fill out the claim form following the step-by-step instructions for each item on the form, referring to this handbook for clarification when necessary.

How to Complete the CMS-1500 Claim Form

Introduction

This section contains an illustration of the CMS-1500 claim form, step-by-step instructions, and a sample of a completed form.

Illustration 1-1. Revised CMS-1500 Claim Form (front)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA　　　　PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes**, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___　　3. ___ . ___

2. ___ . ___　　4. ___ . ___

22. MEDICAID 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. BALANCE DUE $

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Incorporated by reference in 59G-4.001, F.A.C.

Illustration 1-2. Revised CMS-1500 Claim Form (back)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Incorporated by reference in 59G-4.001, F.A.C.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
1	**Medicare and Medicaid**	For an initial claim submission, enter an "X" in the applicable boxes. If the patient is eligible for Medicaid only, enter an "X" in the Medicaid box. For Medicare-Medicaid crossover claims, enter an "X" in both the Medicare and Medicaid boxes and attach the EOMB. To request an ADJUSTMENT or VOID to the most recently paid Medicaid claim, enter an "A" or "V" in the Medicaid box. Enter the 13-digit Internal Control Number (ICN) assigned to the paid claim in the upper left corner, above the top line of the form. For a legacy claim that the prior Medicaid fiscal agent processed that has a 17-digit Transaction Control Number (TCN), enter the TCN. The ICN can be found on the remittance advice that reported the incorrect payment. For a claim that was adjusted, but still has not paid correctly, use the ICN of the last adjustment that paid. If the ICN does not appear on the top of the claim form and an "A" or "V" is entered in the Medicaid box, the adjustment or void request cannot be processed and will be returned to the provider. Note: See Chapter 2 in this handbook for additional information on adjustments and voids. See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare-Medicaid crossover claims. Note: See Appendix A for the Internal Control Number (ICN) Regions Codes.
1a	**Insured's ID Number**	Enter the recipient's ten-digit Medicaid Identification (ID) Number. Do not enter the eight-digit number on the Medicaid ID card. This is a card control number, not the recipient's Medicaid ID number. For Medicare crossover claims, enter the Medicare Identification number in this item. Newborn Billing: See Presumptively Eligible Newborns in Chapter 3 of the Florida Medicaid Provider General Handbook.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
2	**Patient's Name**	Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medicaid Identification Card or other proof of eligibility.
3	**Patient's Birth Date** **Patient's Sex**	Enter the recipient's date of birth in eight-digit month, day, year format (MM/DD/CCYY). Example: for August 21, 1997, enter 08/21/1997. Use an "X" to mark the appropriate box, male or female.
4	**Insured's Name**	No entry required unless the recipient is covered by other insurance. If there is other insurance, enter the name of the insured. If the insured and the patient are the same person, enter the word "SAME."
5	**Patient's Address**	No entry is required, but the information may be helpful to identify a recipient if the Medicaid ID number is incorrect.
6	**Patient's Relationship to Insured**	No entry required.
7	**Insured's Address**	No entry required unless the recipient is covered by other insurance.
8	**Patient Status**	No entry required.
9a-d	**Other Health Insurance Coverage**	Enter the requested information if the recipient has other insurance. In field 9d, enter the primary insurance plan name; do not enter the name of the insurance agency or agent. Attach the Explanation of Benefits (EOBs) for the primary insurance and any other insurers. Enter the word "none" or "not applicable" if there is no other insurance coverage. If the patient has Medicare coverage, bill Medicare first. <u>Note</u>: See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare crossover claims. See Chapter 2 in this handbook for information on billing Medicaid when there is a discount contract.
10a-c	**Is Patient's Condition Related to:**	Enter an "X" in any part(s) that apply and give corresponding information in Item 10a-c.
10d	**Reserved for Local Use**	No entry is required for Medicaid only billing. For Medicare crossover claims, enter the recipient's ten-digit Medicaid ID number.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
11a-d	**Insured's Group No.**	No entry required.
12	**Patient's or Authorized Person's Signature**	No entry required.
13	**Insured's or Authorized Person's Signature**	No entry required.
14	**Date of Current Illness, Injury or Pregnancy**	No entry required.
15	**Dates of Same or Similar Illness**	No entry required.
16	**Dates Patient Unable to Work**	No entry required.
17	**Name of Referring Provider or Other Source**	Enter the name (first, middle initial and last) and credentials of the professional who referred or ordered the service(s) or supply(s) being billed on the claim. Do not use periods or commas within the name. A hyphen can be used for hyphenated names. For example: Jane A Smith MD The referring provider and treating provider cannot be the same individual. A MediPass primary care provider must leave this item blank if he personally rendered the service. Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass primary care provider, or did not require service authorization.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
17a	**Qualifier and Other Provider ID Number (Shaded Area) for the Referring Provider**	This item consists of two fields: one small field to the right of the item number 17a, followed by a larger field. In the small field, enter the qualifier code that indicates what the number in the large field represents. The qualifier codes are used to identify a number that is **not** an NPI number. The qualifier codes used with Medicaid claims are: 9F MediPass Referral or Service Authorization Number 1D Medicaid Provider Number ZZ Provider Taxonomy **MediPass**: For a procedure that requires a MediPass referral, enter qualifier code 9F in the small field to the right of 17a, and enter the MediPass primary care provider's nine-digit authorization number in the large field. The referring provider and treating provider cannot be the same individual. MediPass primary care providers must leave this item blank for services that they personally rendered. MediPass referral numbers did not change when NPI was implemented. Continue to enter the MediPass referral number in Field 17a and leave field 17b blank. **Medical Foster Care and Prescribed Pediatric Extended Care Centers:** For services that are authorized after July 1, 2008, Medical Foster Care and Prescribed Pediatric Extended Care Center providers will receive a prior authorization number from the Medicaid fiscal agent instead of a service authorization number from the area Medicaid office service authorization nurse. For services for which the provider received a prior authorization number from the Medicaid fiscal agent, enter the prior authorization number in field 23. For services authorized prior to July 1, 2008, enter qualifier code 9F in the small field to the right of 17a, and enter the service authorization number in the large field. (Continued)

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
17a	**Qualifier and Other Provider ID Number for the Referring Provider (Continued)**	**Project AIDS Care Home and Community-Based Waiver Services:** Enter qualifier code 9F in the small field to the right of 17a, and enter the service authorization number in the large field. **Targeted Case Management Services**: No entry is required. **Referral Procedures**: For a non-MediPass or service authorization referred procedure, such as a consultation, enter qualifier code 1D in the small field to the right of 17a, and enter the referring physician's nine-digit Medicaid provider number in the large field. If the referring physician is not a Medicaid provider, enter the physician's name in field 17 and qualifier code 1D and pseudo provider number 000000100 in field 17a. You may enter either qualifier code 1D and the Medicaid provider number in 17a or the NPI number in 17b. If you enter the NPI in 17b and the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ in the small field and enter the referring physician's taxonomy in the large field of 17a. Florida Medicaid recommends that you enter the Medicaid provider number on paper claims. Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass primary care provider, or did not require service authorization.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
17b	NPI	Enter either qualifier code 1D and the Medicaid provider number in 17a or the NPI number in 17b. If you enter the NPI in 17b and the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, in item 17a, enter qualifier code ZZ in the small field and enter the referring physician's taxonomy in the large field of 17a. Florida Medicaid recommends that you enter the Medicaid provider number on paper claims. **For MediPass and service authorization referrals, leave item 17b blank and enter the referral number in item 17a.**

Summary of Items 17a and Item 17b:

Type of Referral	Field	Qualifier	Data Requested
MediPass referral	17a	9F	MediPass primary care provider's nine-digit authorization number
	17b	NPI	Blank
Service Authorization	17a	9F	For Project AIDS Care waiver services, enter qualifier 9F and the service authorization number in field 17a. For Medical Foster Care and PPEC services that are authorized after July 1, 2008, providers will receive a prior authorization number from the Medicaid fiscal agent instead of a service authorization number from the area Medicaid office service authorization nurse. Enter the prior authorization number in field 23.
	17b	NPI	Blank
Referral Procedures	17a	Enter either qualifier 1D and the Medicaid provider number in 17a or enter the NPI in 17b. If you enter the NPI in 17b, leave 17a blank unless the taxonomy is needed to identify the referring physician in the Medicaid claims processing system. If yes, enter qualifier ZZ and the taxonomy in 17a. Florida Medicaid recommends that you enter the Medicaid provider number on paper claims.	
	17b	NPI	Referring physician's NPI
Treatment by PCP	17a	None	Leave blank if care was provided by the primary care provider.
	17b	NPI	Blank

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
18	**Hospitalization Dates Related to Current Services**	No entry is required, but an entry is preferred.
19	**Reserved for Local Use**	No entry required. Keyed claim type has been eliminated
20	**Outside Lab**	No entry required.
21	**Diagnosis or Nature of Illness or Injury**	Enter the patient's diagnosis code(s). List up to four ICD-9-CM diagnosis codes in priority order (primary, secondary condition). The primary diagnosis code must be entered first, because it may be linked to the procedure code in the Medicaid claims processing system. Relate lines 1, 2, 3, 4 to the lines of service in 24E by the line number. Use the highest level of specificity. Do not provide narrative description in this field. When entering the diagnosis code, use the space containing a period already printed on the form to separate the two sets of numbers. Diagnosis codes with an "E" or "M" prefix cannot be used for billing Medicaid. Certain diagnosis codes are identified as emergency diagnosis codes. A copayment is not deducted for services using these diagnosis codes. **Ambulance, Wheelchair and Stretcher Vans**: No entry is required. **Child Health Check-Up:** Enter a diagnosis code(s). **Home and Community-Based Waiver Services**: No entry is required. **Independent Laboratories:** Enter a diagnosis only for limited coverage procedures. Labs must enter the diagnosis code from the referring provider when filing claims for MediPass exempt services, family planning waiver services, and genetic testing. See the Florida Medicaid Independent Laboratory Services Coverage and Limitations Handbook for the procedure codes and required diagnosis codes. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, and then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.190, F.A.C. **Physician Specialties:** All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). **Targeted Case Management**: No entry is required.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
22	**Medicaid Resubmission Code**	No entry required. See instructions in claim item 1 for submitting voids and adjustments to paid claims.
23	**Prior Authorization Number**	If the service required prior or post authorization, enter the ten-digit authorization number from the approval letter. Claims for prior and post authorized services are subject to service limitations and the 12-month filing limit. Do not use this field to enter a MediPass referral number. **Medical Foster Care and Prescribed Pediatric Extended Care Centers**: For services that are authorized after July 1, 2008, providers will receive a prior authorization number from the Medicaid fiscal agent instead of a service authorization number from the area Medicaid office service authorization nurse. Enter the prior authorization number in this field. Continue to report the service authorization number on claims for services for which the provider had received a service authorization number from the area Medicaid office service authorization nurse in field 17a. MediPass and service authorization referral numbers are entered in item 17a. **Ambulance, Wheelchair and Stretcher Vans**: Although certain services must be prior authorized, there is no required entry in this item. See Chapter 2 in the Florida Medicaid Ambulance Services Coverage and Limitations Handbook for the prior authorization requirements. **Home and Community-Based Waiver Services:** No entry is required. **Home Health Services**: If home health visits were pre-approved, enter the ten-digit authorization number from the approval letter. Note: See Prior Authorizations in Chapter 3 for information on obtaining authorization for services. Note: See the service-specific Coverage and Limitations Handbook or the Florida Medicaid Provider Reimbursement Schedule for service limitations and the services that require prior authorization. The handbooks are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, and then Provider Support, and then on Provider Handbooks. The handbooks for Medicaid state plan services are incorporated by reference in the Medicaid Services Rule Chapter, 59G-4, F.A.C. The handbooks for waiver services are incorporated by reference in the Medicaid Waiver Programs Rule Chapter, 59G-13, F.A.C.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24	**Section 24 A—J**	The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The shaded area at the top of each of the six claim lines is used to report supplemental information. The shaded area cannot be used to bill for additional services. Supplemental information is placed in the shaded section of 24A through 24G, as defined in each item number. The shaded areas of lines 1 through 6 allow for the entry of 61 characters, from the beginning of 24A to the end of 24G.
24 A	**Date(s) of Service**	Enter date(s) of service, From and To, in the **unshaded area**. If there is one date of service only, enter that date under the From date, and leave the To date blank. If the procedure allows consecutive day billing and is provided for more than one consecutive day, enter the last date of service in the To date. **Exceptions:** **Home and Community-Based Waiver Services:** For procedures that are based on a monthly unit of service, under the **From** date, enter the last day of the month in which the recipient received the service. However, if the recipient was admitted to a hospital or a nursing facility, enter the day before the recipient's admission or the claim will deny. **Targeted Case Management:** For procedures that are based on a monthly unit of service, under the From date, enter the last day of the month in which the recipient received the service. However, if the recipient was admitted to a hospital or a nursing facility, enter the day before the recipient's admission or the claim will be denied. Enter dates in a month, date, year format (MM/DD/YY) using six digits. For example, for January 8, 2007, enter 01/08/07. All services, except those listed below, must be billed with one date of service entered in the From date, per claim line. The To date is not necessary. (Continued)

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 A (continued)	**Date(s) of Service**	**Assistive Care Services (ACS) Providers:** Enter the range of dates when services were provided based on facility documentation. If a recipient received ACS on each day of the month without any hospitalization, nursing facility admission, or leave from the facility, then the first date of service will correspond to the first day of the month and the last date of service will correspond to the last day of the month. If the recipient received services in the facility, then left the facility for any reason and returned within the same month, use more than one claim line to show the actual billable dates of service. **DME and Medical Supplies Providers**: The date an item is made available to the recipient is the date of service. Procedure codes that pay a daily reimbursement (E0202, E0618, E0619, E0781, E0791 and E0935) require From—To dates of service. The dates must be within the same month. Subsequent months must be billed on new claim lines. For orthotics and prosthetics (“L” procedure codes), the date of service is the date the item is ordered. “L” procedure codes must be billed after the device is fitted. For customized wheelchairs the date of service is the date on the letter from the fiscal agent that approves the prior authorization request. The item may not be billed until after the wheelchair has been delivered to the recipient. For rental items: • For the first DME rental claim, the date the item is delivered or made available to the recipient is the date of service. • Subsequent rental claims may be submitted monthly. • For partial month rental payment, see the Florida Medicaid Durable Medical Equipment Medical Supply Services Coverage and Limitations Handbook. **End-Stage Renal Disease-Related Services**: Services rendered for a monthly period, or for consecutive days within one month, may be billed on one line with a From date and a To date. **Hearing aids:** The date of service for all services is the date the device is ordered from the manufacturer. (Continued)

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 A (continued)	**Date(s) of Service**	**Independent Laboratory**: The date of service is the date the tests were ordered on the laboratory service form. **Medical Foster Care Providers:** Services rendered in one calendar month may be billed on one line with a From date and a To date. Services provided during different months must be billed on separate lines. If there is a break in the provision of services, begin a new line. If the child's level of reimbursement changes, a separate line must be completed for each level of care provided. **Physicians, advanced registered nurse practitioners and physician assistants:** Hospital visits that are rendered on consecutive days in one calendar month can be billed on one line with a From date and a To date. **Prescribed Pediatric Extended Care (PPEC) Providers**: Services rendered in one calendar week may be billed on one line with a From date and a To date. **Prosthetic Eyes**: The date of service is the date the provider ordered the eye. **Regional Perinatal Intensive Care Centers (RPICC)**: Enter the admission date in the From date and the date of discharge in the To date. The date of discharge is not reimbursed. **Visual Services**: The provider must use the date that the eyeglasses were dispensed as the date of service on the claim when billing for the eyeglasses (frames, lenses, and add-ons). An exception is if the recipient was ineligible for Medicaid when the eyeglasses are dispensed, the provider may use the date that the eyeglasses were ordered as the date of service when submitting the claim.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 B	**Place of Service**	Enter the two-digit place of service (POS) code in the unshaded area for each procedure performed. The Place of Service Code identifies the location where the service was rendered. **Ambulances and Wheelchair and Stretcher Vans**: No entry required. There is no applicable POS code. Note: See Place of Service Codes in this chapter for the correct place of service codes.
24 C	**EMG**	If the service was an emergency, enter a "Y" for yes in the unshaded area of the field. If the service was not an emergency, leave the item blank. A Medicaid copayment will not be deducted if the service provided was an emergency. Authorization from the MediPass primary care provider is not required if a MediPass recipient has an emergency medical condition. Note: See the definitions of emergency and emergency care and services in the Glossary in the Florida Medicaid Provider General Handbook.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 D	**Procedures, Services or Supplies: CPT/HCPCS and Modifiers**	In the unshaded area, enter the CPT or HCPCS code and modifier(s) from the appropriate code set in effect on the date of service. The specific procedure code(s) must be shown without a narrative description. The allowable procedure codes are listed either on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com (click on Public Information for Providers, and then Provider Support, and then on Fee Schedules) or in the Medicaid service-specific Coverage and Limitations Handbook. **Modifiers**: For certain types of service, a modifier must be entered after the procedure code. Refer to the Medicaid service-specific Coverage and Limitations Handbooks for a list of covered codes and special instructions for using modifiers required to uniquely identify some Medicaid services. The modifier field accommodates the entry of up to four two-digit modifiers. Modifier 99 is used when two or more pricing modifiers are applicable to one procedure code line. Do not use modifier 99 when the procedure code has two local-code modifiers. Use of modifier 99 requires claim review by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code. **Entering a pricing modifier and local-code modifier:** If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first modifier field on the claim form, and enter the local-code modifier in the second modifier field. **By Report**: By report procedures are procedures that must be approved or manually priced. They must be submitted on paper claims forms with relevant reports attached. Procedure codes with modifier 99, procedure codes marked "R" on the Provider Fee Schedules, and other procedures specified in the Medicaid service-specific Coverage and Limitations Handbooks and the Provider Fee Schedules are approved and priced by report.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 D (continued)	**Procedures, Services or Supplies: CPT/ HCPCS Codes and Modifiers**	**HCPCS Codes for Drugs:** Providers who bill HCPCS codes for drugs must enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in the shaded area of item 24. Begin entering the information above 24 A. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units. The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See Chapter 4 in the Florida Medicaid Provider General Handbook for instructions for crossover claims for J3490, Unclassified Drugs, and J9999, Not Otherwise Assigned, Antineoplastic Drugs. Florida Medicaid will only reimburse for drugs for which the manufacturer has a federal rebate agreement per Section 1927 of the federal Social Security Act *[42 U.S.C. 1396r-8]*. The current list of manufacturers who have drug rebate agreements is available on AHCA's website at http://ahca.myflorida.com. Click on Medicaid, scroll down to "What is Occurring in Medicaid," and then click on "Current List of Drug Rebate Manufacturers." The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows: • For a 4-4-2 digit number, add a 0 to the beginning • For a 5-3-2 digit number, add a 0 as the sixth digit. • For a 5-4-1 digit number, add a 0 as the tenth digit. Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are: F2 – International Unit GR – Gram ML – Milliliter UN – Unit

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			
N400026064871UN1234												
10	01	05	10	01	05	11		J1563				

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 D (continued)	**Procedures, Services or Supplies: CPT/ HCPCS Codes and Modifiers**	**Ambulances and Wheelchair and Stretcher Vans**: In the first modifier field, enter both the origin modifier and the destination modifier. The field holds two alpha characters. Do not enter the destination modifier in the second modifier field. The origin and destination modifier codes are as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than P or H
E	Residential, domiciliary, custodial facility (nursing home, not a skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between types of ambulance
J	Non-hospital based dialysis
N	Skilled nursing facility (SNF)
P	Physician's office, which includes HMO non-hospital facility, clinic, etc.
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at the physician's office in route to hospital (includes HMO non-hospital facility, clinic, etc.). Modifier X can be entered only in the second modifier field.

In the second modifier field, enter the following pricing modifier(s), if applicable:

- Modifier QN, when submitting a claim for a negotiated rate; and
- Modifier 76, when the same provider bills the same procedure code and origin and destination modifier for the same recipient, on the same date of service.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 E	**Diagnosis Pointer**	Enter the diagnosis code reference number (pointer) from Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter the reference number in the unshaded area left justified in the field. (Do not enter the ICD-9-CM number in this item. It can be entered only in Item 21.) Enter only one reference number per line item unless instructed otherwise in the service-specific Coverage and Limitations Handbook. If more than one diagnosis reference is required by the Medicaid service-specific Coverage and Limitations Handbook, you must use a comma (,) separator between the diagnosis code pointers. When multiple services are performed, enter the primary reference number for each service (either "1", "2", "3", or "4"). **Ambulance, Wheelchair and Stretcher Vans**: No entry is required. **Home and Community-Based Waiver Services**: No entry is required. **Targeted Case Management**: No entry is required.
24 F	**Charges (Unshaded Area)**	Enter the usual and customary charge for the procedure performed. Enter the dollar amount in the unshaded area, right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Do not enter dollar signs or negative dollar amounts. Enter the cent amount in the cent area of the field. Enter 00 in the cents area if the charge is a whole number. The decimal must be included. For example: 250.00. This item allows for the entry of six characters to the left of the vertical line and two characters to the right of the vertical line. **Assistive Care Services Provider:** For each line used, enter the total of the payment rate times the number of days shown on that line.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 G	**Days or Units (Unshaded Area)**	Enter the units of service rendered or number of days that the service was rendered for each detail line in the unshaded area. A unit of service is the number of times a procedure is performed. When only one procedure is performed, enter a “1” in the item. If a procedure code for consecutive days is billed on one claim line using the From—To dates, enter the appropriate number of units in item 24G. **Home and Community-Based Waiver Services:** Enter the units of service rendered for the procedure code. If multiple units of the same procedure were performed on the same date of service, enter the total number of units. If the date of service covers a span of time, i.e., a month, enter the total number of units for that span of time. **Targeted Case Management**: Enter the units of service rendered for the procedure code. If multiple units of the same procedure were performed on the same date of service, enter the total number of units. If the date of service covers a span of time, i.e., a month, enter the total number of units for that span of time. **The definition of unit varies by service. Please see the service-specific Coverage and Limitations Handbook for information on how to compute a unit of service.** Enter the numbers right justified in the field. Do not use leading zeros.
24 F	**Third Party Coverage Shaded Area**	Third Party Coverage: If payment from a primary insurance carrier is expected or already received, enter the identifier IP for Individual Policy or GP for Group Policy and enter the paid or expected amount in the shaded area of Items 24 F and G. Do not enter payments received from Medicare. Do enter payments received from Medicaid copayments. Do not use commas when reporting dollar amounts. Do not enter dollar signs or negative dollar amounts. Enter 00 if the charge is a whole number. The decimal must be included. For example: 250.00. If no payment was received or if the service was denied, leave the item blank and attach a copy of the explanation of benefits (EOB) from the insurance carrier that indicates the reason for the denial to the claim.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 H	**EPSDT and Family Planning Indicator (Unshaded Area)**	This item allows for the entry of one character in the unshaded area. Enter an “E” if the patient was referred for the services as a result of a Child Health Check-Up screening. (Child Health Check-Up was formerly named EPSDT.) If the service is a surgery that was referred as a result of a Child Health Check-Up screening, an “E” in this item will indicate to the system that prior authorization was not required.
	Child Health Check-Up Referral Code Indicator	If the service is a Child Health Check-Up, enter the referral code that identifies the health status of the child:

V	**Patient Refused Referral/Available Not Used** Indicator is used when the patient refused a referral.
U	**Patient Not Referred/Not Used** Indicator is used when there are no referrals made.
2	**Under Treatment** Indicator is used when patient is currently under treatment for referred diagnostic or corrective health problem.
T	**New Services Requested** Indicator is used for referrals to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic check-up (not including dental referrals).

CLAIM ITEM	TITLE	ACTION
	Family Planning Indicator	Enter an “F” if the services relate to a pregnancy or if the services were for family planning. If the service requires a copayment, an “F” in this item will indicate that the recipient received a pregnancy-related service or family planning, and the copayment will not be deducted from the provider’s reimbursement.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 H	**Shaded Area**	**Hospice:** For all recipients in hospice, enter "H" in the shaded area of Item 24H.
24 I	**ID Qualifier—Shaded Area**	Enter the individual rendering (treating) provider's qualifier code in the shaded area of item 24 I. The rendering provider's other ID number is reported in item 24 J in the shaded area. Enter the rendering provider's ID number only when it is different from the pay-to provider number that is entered in items 33a or 33b. If entering the rendering provider's Medicaid provider number, enter qualifier code 1D. If entering the rendering provider's NPI and the NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code in the shaded area of item 24 J.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 J	**Rendering Provider ID #**	**Treating Provider:** Enter the individual rendering (treating) provider's number in Item 24 J. Enter the rendering provider's ID number only when it is different from the pay-to provider number that is entered in items 33a or 33b. **Entry of NPI on paper claims is optional. Florida Medicaid recommends that you continue to enter Medicaid provider numbers on paper claims.** If entering the rendering provider's NPI and if the rendering provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code in the shaded area of item 24 I and enter the taxonomy code in the shaded area of item 24 J. If more than one treating provider in the group rendered services to the same recipient on the same date of service, enter the number for the treating provider who actually rendered the service on the claim line. **Early Intervention Services**: When the provider number in item 33 is a group number, enter the individual treating provider's number. Services rendered by professional and paraprofessional staff cannot be billed on the same claim form. **Child Health Check-Up:** When the provider number in item 33 is a group number, enter the Child Health Check-Up treating provider's number in 24J.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
25	**Federal Tax ID Number**	No entry required.
26	**Patient's Account Number**	The provider may enter a recipient account number so that it will appear on the remittance advice. Any letter or number combination up to 10 digits may be entered. Enter the numbers left justified in the field.
27	**Accept Assignment**	No entry required.
28	**Total Charge**	Add together all charges in the column under item 24F, and enter the total amount in this item in dollars and cents format, i.e., 250.00. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Do not enter dollar signs. Enter 00 in the cents area if the amount is a whole number. This field allows for the entry of seven characters to the left of the vertical line and two characters to the right of the vertical line.
29	**Amount Paid**	Enter the amount paid by other health insurance coverage if applicable. This amount must equal the total of the TPL entries in shaded area of column 24 F. The amount must be entered in dollar and cents format, including the decimal. For example: 250.00. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Do not enter dollar signs. Enter 00 in the cents area if the amount is a whole number. This field allows for the entry of six characters to the left of the vertical line and two characters to the right of the vertical line. Do not enter prior Medicaid payments here when filing an adjustment invoice. Do not enter Medicare payments here when filing a Medicare and Medicaid crossover claim. Do not enter the Medicaid copayment amount in this item.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
30	**Balance Due**	No entry required.
31	**Signature of Physician or Supplier Including Degrees or Credentials and Date**	Sign and date the claim form. If the provider uses a facsimile signature or a signature stamp, the entry must be initialed. The provider is responsible for ensuring that the signature on the claim is that of an authorized individual. The authorized signature certifies that the information entered on the claim is in conformance with the conditions on the back of the claim form and with all federal and state laws and regulations. State laws and regulations include the regulations applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA. Providers are responsible for all claims billed using their Medicaid provider identification numbers. (See Electronic Claims Submissions in this chapter for information on electronic claim certification.) “Signature on file” may be used only if the provider’s billing agent or authorized designee has a written attestation signed by the provider that allows the billing agent or authorized designee to file claims on the provider’s behalf. The attestation must be maintained on file at the billing agent’s or authorized designee’s office. The attestation must be readily available upon AHCA’s request. Enter the date that the form was signed in six-digit format (MM/DD/YY). For example, for January 15, 2007, enter 01/15/07.
32	**Service Facility Location Information**	Enter the name, address, city, and zip code of the location where the services were rendered in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code plus 4. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main St., #101). Enter a space between the town name and state code; but do not include a comma. When entering a nine-digit zip code, include the hyphen. If services were rendered in the recipient’s home, no entry is required.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
32a	**NPI**	No entry required.
32b	**Other ID#**	No entry required.
33	**Biller Provider Info & PH #**	Item 33 identifies the provider who is requesting to be paid. Enter the billing provider's name, address, zip code and telephone number. Enter the telephone number in the area to the right of the item title. Enter the provider's name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code plus 4 Providers must enter the zip code plus 4 in order to be correctly identified in the Medicaid claims processing system. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main St., #101). Enter a space between the town name and state code; do not include a comma. When entering a nine-digit zip code, include the hyphen.
33a	**NPI**	**Entry of NPI on paper claims is optional. Florida Medicaid recommends that you continue to enter Medicaid provider numbers on paper claims.** If entering the pay to provider's NPI, enter it in this field. If the rendering provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code ZZ and the taxonomy code in item 33b. If not entering the NPI, leave blank.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
33b	**Other ID#**	If entering the pay to provider's Medicaid provider number, enter it in this item preceded by the qualifier code 1D (qualifier code 1D stands for Medicaid provider number). Do not enter a space, hyphen, or other separator between the qualifier and Medicaid number. For example: 1D123456789. If entering the pay to provider's NPI in item 33a and if the NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code. If the provider is a group provider, the group number must be entered in item 33, and the individual treating provider number must be entered in item 24 J for each claim line billed. Medicaid payment will be made to the provider whose number is entered in item 33a or 33b. That provider number is used to report Medicaid payments to the IRS. Only one provider number can be entered in claim item 33a or 33b.
33a and 33b	**Provider Number**	**Early Intervention Services**: Group providers are assigned two group provider numbers for billing early intervention services: one for services rendered by professional staff and one for services rendered by paraprofessional staff. The provider must bill for services rendered by professional and paraprofessional staff on separate claim forms using the appropriate group provider number. The provider's early intervention services provider number can be used only for early intervention services. If the provider is enrolled in another program, such as therapy services, the provider must use that service-specific provider number for billing those services. A provider cannot bill for different types of Medicaid services on the same claim form.

Place of Service Codes (POS)

Code	Description
03	**School** A school facility where a recipient receives a Medicaid service.
11	**Office** Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, intermediate care facility (ICF), or mobile van where the health professional routinely provides health examination, diagnosis and treatment of illness or injury on an ambulatory basis.
12	**Patient's Home** Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	**Assisted Living Facility** Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	**Group Home** Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.
21	**Inpatient Hospital** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non surgical) and rehabilitation services, by or under the supervision of physicians, to patients admitted for a variety of medical conditions.
22	**Outpatient Hospital** A portion of a hospital that provides diagnostic, therapeutic (both surgical and non surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Place of Service Codes (POS), continued

Code	Description
23	**Emergency Room - Hospital** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided on a 24-hour basis.
24	**Ambulatory Surgical Center** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	**Birthing Center** A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.
31	**Skilled Nursing Facility** A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.
32	**Nursing Facility** A facility that primarily provides residents with skilled nursing care and related services for rehabilitation of an injured, disabled, or sick person; or on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	**Custodial Care Facility** A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	**Hospice** A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. Note: This place of service can only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service must be used.

Place of Service Codes (POS), continued

Code	Description
49	**Independent Clinic** A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
51	**Inpatient Psychiatric Facility** A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. This place of service code is only used for Medicare crossover billing.
53	**Community Mental Health Center** A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	**Intermediate Care Facility for the Developmentally Disabled (IFC-DD)** A facility that primarily provides health-related care and services above the level of custodial care to developmentally disabled individuals, but does not provide the level of care or treatment available in a hospital or a skilled nursing facility.
55	**Residential Substance Abuse Treatment Facility** A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Place of Service Codes (POS), continued

Code	Description
57	**Non-residential Substance Abuse Treatment Facility** A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
62	**Comprehensive Outpatient Rehabilitation Facility** A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities.
65	**End Stage Renal Disease Treatment Facility** A facility other than a hospital, which provides dialysis treatment, and maintenance or training to patients or caregivers.
71	**State or Local Public Health Clinic** A facility maintained by either state or local health departments that provides ambulatory primary care under the general direction of a physician.
72	**Rural Health Clinic or Federally Qualified Health Center** A certified facility located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	**Independent Laboratory** A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician’s office.
99	**Other Unlisted Facility** Other service facilities not identified above.

Illustration 1-3. Sample of a Completed CMS-1500 Claim Form with MediPass Referral and Third Party Payment Billing Using the Medicaid Provider Number.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 04 27 1956 SEX M F X

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. PATIENT STATUS: Single Married Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed | Full-Time Student | Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Jane Smith MD

17a. 9F 012345600

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 620 . 8

2. ___ . ___

3. ___ . ___

4. ___ . ___

22. MEDICAID 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								1P 200.00			1D	765432100
	07 06 08		21		58275		1	850.00			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 $ 850.00

29. AMOUNT PAID $ 200.00

30. BALANCE DUE $

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.)

Charley Jones, MD 07-16-08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Good Samaritan Hospital
13 Main Street
Goodtown FL 32301-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # (850) 220-1440

Florida Medical, PA
130 Main Street
Goodtown FL 32301-1234

a. NPI b. 1D123456900

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Illustration 1-4. Sample of a Completed CMS-1500 Claim Form For an Injectable Drug with Third Party Payment Billing Using the Provider's NPI

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE (MM DD YY): 04 27 1956 SEX: M [ ] F [X]

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. PATIENT STATUS: Single, Married, Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed, Full-Time Student, Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Jane Smith MD

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 620 . 8

2.

3.

4.

22. MEDICAID 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 CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 N412345678901UN1234							1P 250.00			ZZ	207VG0400X
07 06 08		11		J1563		1	850.00			NPI	1234567890
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 $ 850.00

29. AMOUNT PAID $ 250.00

30. BALANCE DUE $

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.)

Charley Jones, MD 07-06-08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Good Samaritan Hospital
13 Main Street
Goodtown FL 32301-1234

a. NPI b.

33. BILLING PROVIDER INFO & PH # (850) 220-1440

Florida Medical, PA
130 Main Street
Goodtown FL 32301-1234

a. 0987654321 b. ZZ207VG0400X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Illustration 1-5. Sample of a Completed CMS-1500 Claim Form For a Project AIDS Care Waiver Service

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0987654321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 01 31 1955 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street) | CITY | STATE | ZIP CODE | TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street) | CITY | STATE | ZIP CODE | TELEPHONE (Include Area Code) ( )

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 9F 012345600

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID 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	08 09 08		12		97124	U8		35.00	4		NPI	
2	08 23 08		12		97124	U8		35.00	4		NPI	
3	09 08 08		12		97124	U8		35.00	4		NPI	
4	09 20 08		12		97124	U8		35.00	4		NPI	
5	10 06 08		12		97124	U8		35.00	4		NPI	
6	10 08 08		12		97124	U8		35.00	4		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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 $ 210.00

29. AMOUNT PAID $

30. BALANCE DUE $

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 Mary Massage DATE 10/22/08

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (850) 220-1440

Mary's Therapy

4321 Every Street

Any City FL 11123-4567

a. NPI b. 1D688817200

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Illustration 1-6. Sample of a Completed CMS-1500 Claim Form For an Adult Mental Health Targeted Case Management Service

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) X / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Florida, Joseph

3. PATIENT'S BIRTH DATE (MM DD YY): 03 05 1960 — SEX: M X

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

5. PATIENT'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code)

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) — SEX M / F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES / NO X

b. AUTO ACCIDENT?: YES / NO X — PLACE (State)

c. OTHER ACCIDENT?: YES / NO X

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM DD YY) — SEX M / F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM / TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM / TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	24A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 01 08		11		T1017			36.00	3		1D / NPI	246813500
2	08 10 08		11		T1017			48.00	4		1D / NPI	246813500
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: $ 84.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

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.)

Susie Case Manager 09/20/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI — b.

33. BILLING PROVIDER INFO & PH # (850) 220-1440

Best Services
123 Any Street
Home Town FL 00022-4111

a. NPI — b. 1D234567800

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Claims Submission Checklist

Introduction

Use the following checklist before submitting a claim to the Medicaid fiscal agent for reimbursement.

Checklist

- ❑ Is the form typed or printed in black ink?
- ❑ Is the form legible?
- ❑ Were instructions in the handbook followed? Some items are not self-explanatory or may be used for other purposes.
- ❑ Are the provider name and number entered?
- ❑ Is the claim signed and dated? Unsigned claims will be returned unprocessed.
- ❑ Are attachments required? Claims cannot be paid without the required attachments.
- ❑ Is the MediPass authorization number included in item 17a on the CMS-1500 for services that require the MediPass primary care provider's approval? Is the referring provider identification number included in item 17a for procedure codes requiring a referring provider identification number? Without this number, payment will be denied.
- ❑ Is the Prior Authorization number included in item 23 on the CMS-1500 for services that require prior authorization from Medicaid? Without this number, payment will be denied.
- ❑ If the P.O. Box Number for submitting the claim correct?

Note: See Where to Send Claim Forms on the next page for a complete list of addresses to submit claims and other forms.

If your question is not answered in this handbook, call the Medicaid fiscal agent Provider Contact Center at 800-289-7799 and select Option 7. The Provider Contact Center is open from 7:00 a.m. to 6:00 p.m. Eastern Time.

Claims Mailing Checklist

Introduction

The following checklist may be used when mailing claims to the Medicaid fiscal agent for reimbursement.

Checklist

- ❑ Enclose only one claim type per envelope, i.e., clean CMS-1500, adjustment CMS-1500, or void CMS-1500. Claims and adjustment requests should be sent separately, because they are processed separately at the Medicaid fiscal agent.
- ❑ The claims envelope should be addressed to the correct P.O. box and corresponding nine-digit zip code specific to the claim type being mailed. Printed addresses speed up post office processing.
- ❑ Claims mailed in a large envelope or "flat" should be marked "First Class" and paid for as first class postage. If First Class is not specified, the post office will send large envelopes as Third Class mail. This will delay delivery of claims to the Medicaid fiscal agent.

Where to Send Claim Forms

CLAIM TYPE	ADDRESS
Original CMS-1500 **Resubmitted CMS-1500**	CMS-1500 Claims P.O. Box 7072 Tallahassee, Florida 32314-7072
CMS-1500 Crossover	CMS-1500 Crossover Claims P.O. Box 7074 Tallahassee, Florida 32314-7074
Adjustments and Voids	Adjustments and Voids P.O. Box 7080 Tallahassee, Florida 32314-7080
Exceptions to Filing Time Limits	Area Medicaid Office (See Appendix C in the Florida Medicaid Provider General Handbook for the address.)
Prior Authorization Request	Prior Authorizations P.O. Box 7090 Tallahassee, Florida 32314-7090
Newborn Claims	Newborn Claims (Member 88) P.O. Box 7092 Tallahassee, Florida 32314-7092
RPICC Claims **(Regional Perinatal Intensive Care Centers)**	RPICC Claims P.O. Box 7084 Tallahassee, Florida 32314-7084

Electronic Claim Submission

Introduction

Submitting Medicaid claims via electronic media offers the advantage of speed and accuracy in processing. Providers may submit electronic claims themselves or choose a billing agent that offers electronic claim submission services. Billing agents must enroll as Medicaid providers.

Benefits

The benefits of electronic claims submission include:

- Increase speed of claims payments; seven days in some cases.
- Correct data entry errors immediately, avoiding mailing time and costs.
- Eliminate the cost and inconvenience of claims paperwork.
- Reduce office space required for storing claim forms, envelopes, etc.
- Decrease clerical labor costs.
- Automate the office for a more efficient operation.

Free Software and Electronic Claims Submissions Options

Providers can upload claims directly to the Medicaid fiscal agent through the fiscal agent's secure Web Portal. The secure Web Portal provides interactive claims processing for near real-time adjudication.

The Medicaid fiscal agent will also provide free PC-based software, called Provider Electronic Solutions (PES), to enable providers to submit claims electronically on personal computers (PC) in their offices.

The PES software, user manual and technical support is available free of charge to Florida Medicaid providers.

Note: For technical support or more information about obtaining the PES software, visit the fiscal agent's Web Portal at http://mymedicaid-florida.com, click on Public Information for Providers, and then on EDI. It is also available by calling the EDI Help Desk at 866-586-0961 or 800-289-7799 and selecting Option 3.

Format Specifications

If you have a practice management system, use a billing agent, claims clearinghouse, or code your own submission software, the fiscal agent has specifications available detailing the electronic formats and the communications requirements.

How to Participate in Electronic Claims Submission

The fiscal agent's field representatives will assist providers with installing and testing PES software and provide instructions for ongoing claims submission. To schedule an appointment with a field representative or for answers to non-software questions, call the fiscal agent's Provider Contact Center (PCC) at 800-289-7799 and select Option 7.

Electronic Claim Submission, continued

Technical Support

The Electronic Data Interchange (EDI) Support Unit assists providers who have questions about electronic claims submission. The fiscal agent's EDI Help Desk is available to all providers Monday through Friday from 8:00 a.m. to 5:00 p.m. EST at 866-586-0961 or 800-289-7799, select Option 3.

EDI Support will:

- Provide information on available services.
- Assist in enrolling users for electronic claims submission and report retrieval.
- Process test transmissions.
- Provide technical assistance on transmission difficulties.

Note: Information on EDI is available on the fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, and then on EDI.

Claim Certification

Because an electronic claim cannot be submitted with a signature, the provider's endorsed signature on the back of the remittance check issued by the Medicaid fiscal agent takes the place of a signature on a paper claim form. It acknowledges the submission of the claim and the receipt of the payment for the claim. It certifies that the claim is in compliance with the conditions stated on the back of the paper claim form and with all federal and state laws.

Any provider who utilizes the electronic funds transfer system is certifying with each use of the electronic funds transfer system that the claim(s) for which the provider is being paid is in compliance with the provisions found on the back of the paper claim form and with all federal and state laws.

CHAPTER 2
CLAIMS PROCESSING

Overview

Introduction

Claims for Medicaid reimbursement are processed by the Medicaid fiscal agent. This chapter describes claims processing and gives the provider information about remittance advice and how to obtain help with claims processing problems.

In this Chapter

This chapter contains:

Topic	Page
Claims Processing	2-1
Remittance Advice (RA)	2-2
How to Read the Remittance Advice	2-6
Sample Remittance Advice	2-7
How to Resubmit a Denied Claim	2-18
Resolving an Incorrect Payment	2-19
How to File a Void Request on a Paper Claim	2-21
Sample Void Request—CMS-1500 Claim Form	2-24
How To File an Adjustment Request on a Paper Claim	2-25
Sample Adjustment Request—CMS-1500 Claim Form	2-28
Identifying Adjustments and Voids on the Remittance Advice	2-29
Billing Medicaid When There is a Third Party Liability Discount Contract	2-30

Claims Processing

Paper Claim Handling

When the Medicaid fiscal agent receives a paper claim, it is screened for missing information and necessary attachments. If information or documentation is missing, the claim will not be entered into the Florida Medicaid Management Information System (FMMIS). It will be returned to the provider with a Return to Provider (RTP) letter that will state the reason the claim is being returned. The provider needs to correct the error, attach any missing documentation, and return the claim to the Medicaid fiscal agent for processing.

Claim Entry

Data entry operators image and key into FMMIS each paper claim that passes initial screening. Electronic claims are loaded by batch into FMMIS by the fiscal agent's data processing staff.

Claims Processing, continued

Claim Adjudication

FMMIS analyzes the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

Disposition of Claim

A claim disposition can be:

- Paid: payment is approved in accordance with program criteria.
- In Process: the claim is put on "hold" so it can be analyzed in more detail by the fiscal agent or Medicaid.
- Denied: payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.

Processing Time Frames

Claims are processed daily. Payments are made on a weekly basis. Under normal conditions, a claim can be processed from receipt to payment within 7 to 30 days.

Remittance Advice (RA)

Description

The remittance advice (RA) displays the disposition of all claims processed during the claims cycle for each provider service location. If a provider has more than one service location, a separate remittance advice is delivered each week in a paper or electronic format, if the fiscal agent processed any claims or put any claims in "In Process" status for that provider. If the provider receives payment by paper check, the paper check is mailed in a separate envelope to the "Pay-To" address.

Remittance Advice (RA), continued

Role of the Remittance Advice (RA)

The remittance advice (RA) plays an important role in communications between the provider and Medicaid. It tells what happened to the claims submitted for payment – whether they were paid, denied, in process, or adjusted. It provides a record of transactions and assists the provider in resolving errors so that denied claims can be resubmitted.

The remittance advice must be reconciled to the claim in order to determine if correct payment was received. The date on the first line of each page is the date the financial cycle began, e.g., Friday. The issue date is the date the check was mailed to the provider or electronic funds transfer (EFT) was sent to the bank for transmission.

The remittance advice contains one or more of the following sections, depending on the type of claims filed, the disposition of those claims, and any new billing or policy announcements. Each section starts on a new page:

- Remittance Advice Banner Page Message (will be available on every RA)
- Four Disposition Categories: Paid, Denied, In Process, Adjusted
- Financial Transactions
- Third Party Liability (TPL) Section
- Summary Section (will be available on every RA)
- EOB Reason Code Description

Remittance Advice Banner Message (CRA-BANN-R)

When Medicaid or the fiscal agent discovers billing problems encountered by all or select provider types, a remittance advice banner message is printed as the first page of the advice. Suggestions for avoiding problems, explanations of policy, and new or changed procedure codes are described. Training sessions are also announced on the remittance advice banner page.

Remittance Advice (RA), continued

Claim Types with Four Disposition Categories (CRA-XXXX-R)

The CMS-1500 remittance advice will report the four disposition categories of paid, denied, in process, or adjusted claims:

CRA-PHPD-R, Paid
CRA-PHDN-R, Denied
CRA-PHSU-R, In Process
CRA-PDAH-R, Adjustments

Details display in sequence order starting with the first detail; no detail numbers are shown. Each section totals the amounts for each claim type group and disposition category.

Claims will be sorted by recipient name within the disposition, e.g., CMS-1500 - Denied. All claims of the same status for the same recipient will be grouped together on the same page unless a page break is required in which case the claim will continue on the next page.

All claims in the “In Process” status are reported each week until processed as “Paid” or “Denied”. If one line on a claim form suspends, then the entire claim will be “In Process” until all of the claim lines can be processed.

Adjustment claims begin with a “5” in the Internal Control Number (ICN) and include the original claim header information only, followed by the replacement claim header and the details being adjusted.

All reasons the provider was not paid the billed amount will be listed for each claim header and claim detail where applicable. Some of these reasons may be cutback reasons.

Note: See Appendix A for the Internal Control Number (ICN) Region Codes.

Remittance Advice (RA), continued

Financial Transactions (CRA-TRAN-R)	Financial transactions including account receivables, expenditures, and cash receipts are shown in this section. The account receivables are equivalent to credit gross adjustments. The expenditures are equivalent to debit gross adjustments.

Third Party Liability Section (CRA-TPLP-R)

Third Party Liability (TPL) information for denied claims is shown in this section when applicable. TPL information will be shown for any claims denied for TPL. These denied claims will be shown on the claim type pages, and the applicable TPL information will be shown for each denied claim on the TPL page.

If the recipient has other insurance coverage, Medicaid payment will be denied unless the provider indicates receipt of a third party payment, or attaches a denial from the other insurance company, or documentation that the other insurance company will not cover the service.

If the recipient has other insurance, the third party carrier information appears with the denied claim.

The provider should record other insurance coverage information reported on the remittance advice in the recipient's file for future use. Remittance advice insurance information is specific to the individual recipient.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information about TPL. The Florida Medicaid Provider General Handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Note: A list of third party carrier codes and carrier billing information can be obtained from the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Secure Information for Providers, then on TPL. The listing is also available from the fiscal agent's Provider Contact Center (PCC) at 800-289-7799, Option 7.

Summary Section (CRA-SUMM-R)

The Summary Section is used to denote the total of all claims for the provider's remittance advice including Claims Data, Earnings Data, and Current Deductions. The total capitation payment is included on the summary page. Details for capitation payments are sent separately to the provider by Managed Care on the MGD-0002-M Capitation Payment Listing report and the 820 transaction.

Remittance Advice (RA), continued

EOB Reason Code Description (CRA-EOBM-R)

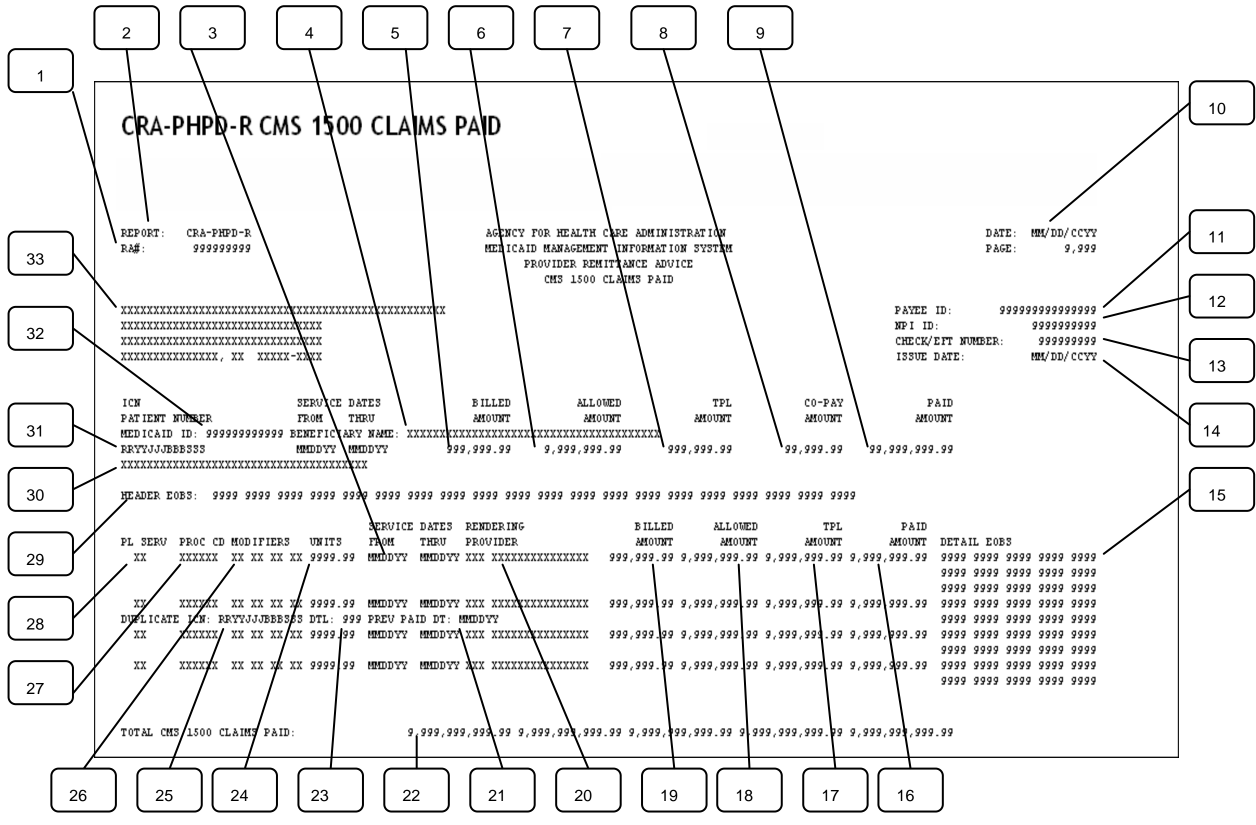
The Explanation of Benefits (EOB) Reason Code section contains an explanation for all EOB codes and reason codes shown on all previous pages of the remittance advice.

How to Read the Remittance Advice

Introduction

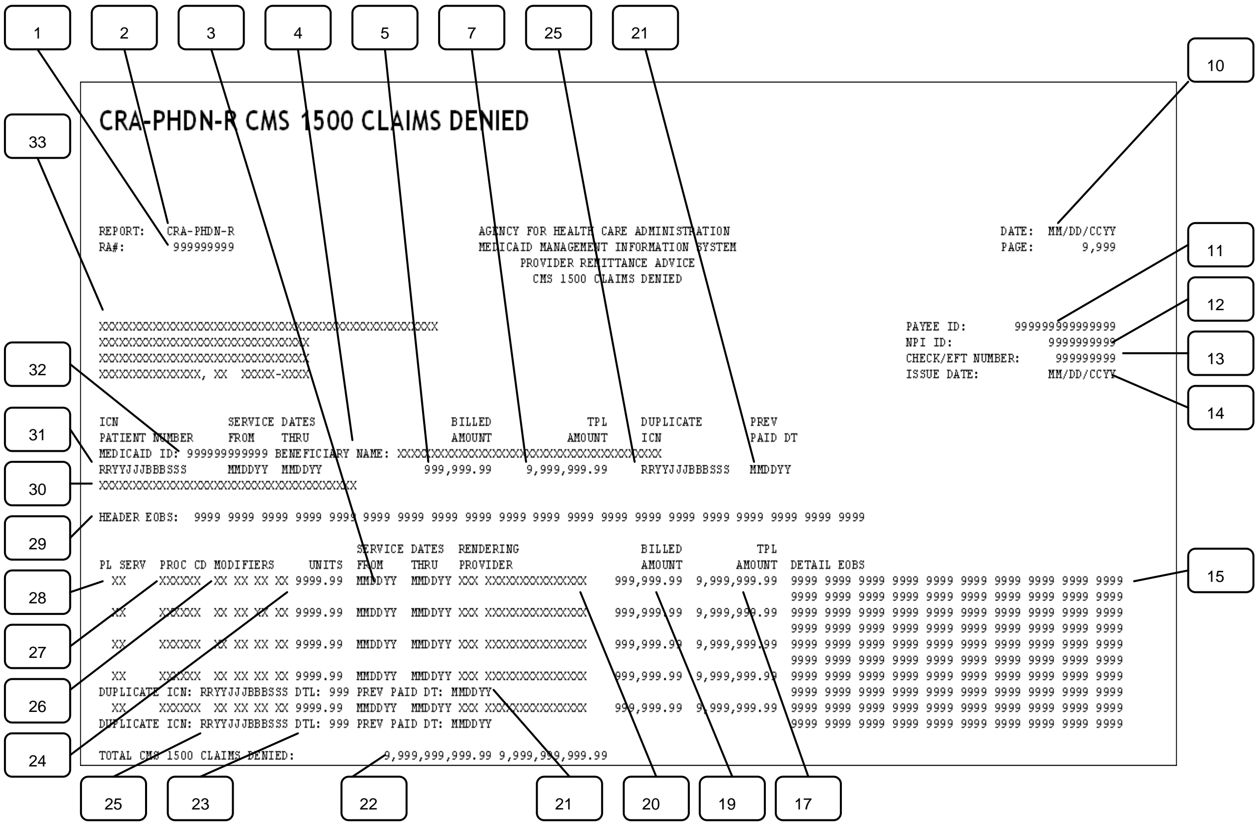
All claims for each provider that are entered in the Florida Medicaid Management Information System (FMMIS) during the weekly cycle are listed on a remittance advice. Following are examples of each type of RA and the field descriptions.

Illustration 2-1. Sample CMS-1500 Claims Paid




```
CRA-PHPD-R CMS 1500 CLAIMS PAID

REPORT:   CRA-PHPD-R                        AGENCY FOR HEALTH CARE ADMINISTRATION                        DATE:  MM/DD/CCYY
RA#:       999999999                        MEDICAID MANAGEMENT INFORMATION SYSTEM                       PAGE:       9,999
                                                 PROVIDER REMITTANCE ADVICE
                                                    CMS 1500 CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                               PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  CHECK/EFT NUMBER:     999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                  ISSUE DATE:          MM/DD/CCYY

ICN                        SERVICE DATES              BILLED          ALLOWED             TPL          CO-PAY            PAID
PATIENT NUMBER             FROM    THRU               AMOUNT           AMOUNT          AMOUNT          AMOUNT          AMOUNT
MEDICAID ID: 999999999999 BENEFICIARY NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS              MMDDYY  MMDDYY         999,999.99     9,999,999.99      999,999.99       99,999.99   99,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                       SERVICE DATES  RENDERING                    BILLED       ALLOWED          TPL          PAID
PL SERV  PROC CD MODIFIERS   UNITS     FROM    THRU   PROVIDER                     AMOUNT        AMOUNT       AMOUNT        AMOUNT  DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
                                                                                                                              9999 9999 9999 9999 9999
                                                                                                                              9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DT: MMDDYY                                                                    9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
                                                                                                                              9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
                                                                                                                              9999 9999 9999 9999 9999

TOTAL CMS 1500 CLAIMS PAID:              9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99
```

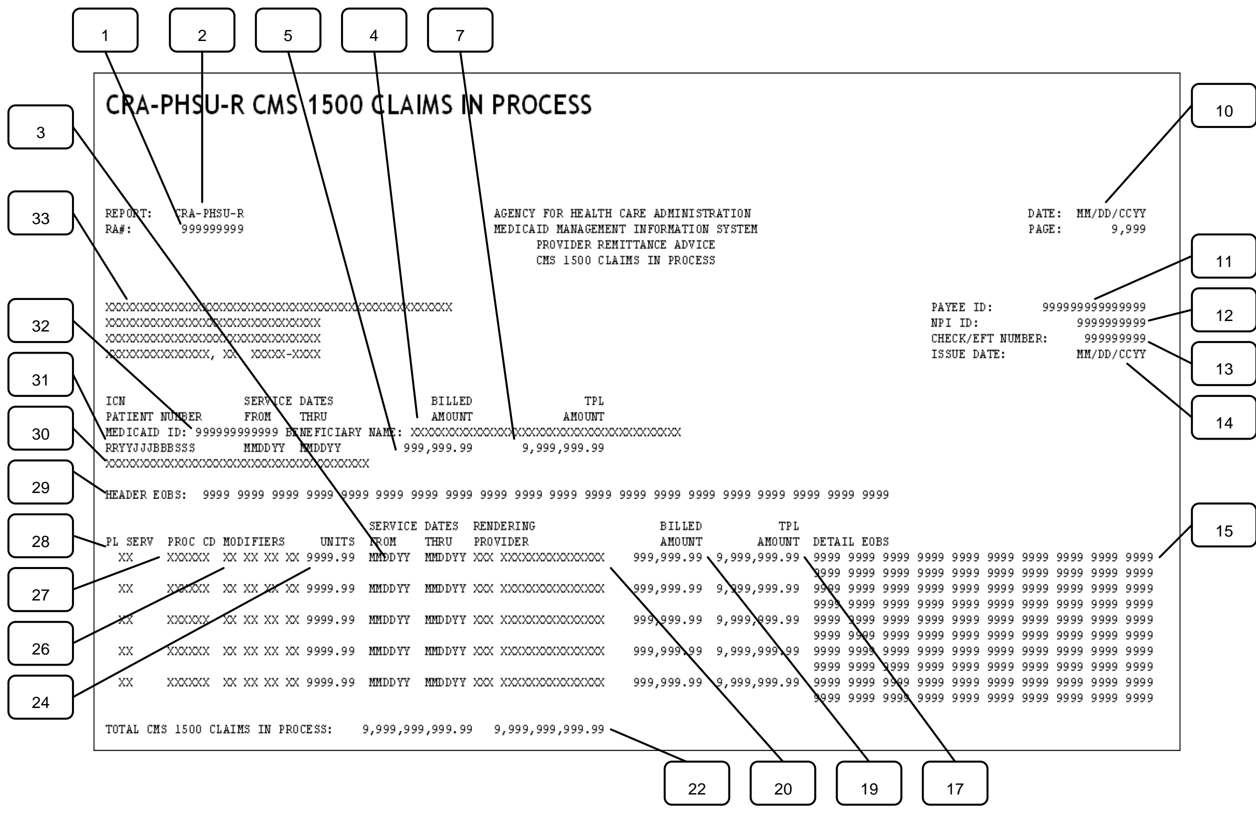
Illustration 2-2. Sample CMS-1500 Claims Denied



CRA-PHDN-R CMS 1500 CLAIMS DENIED

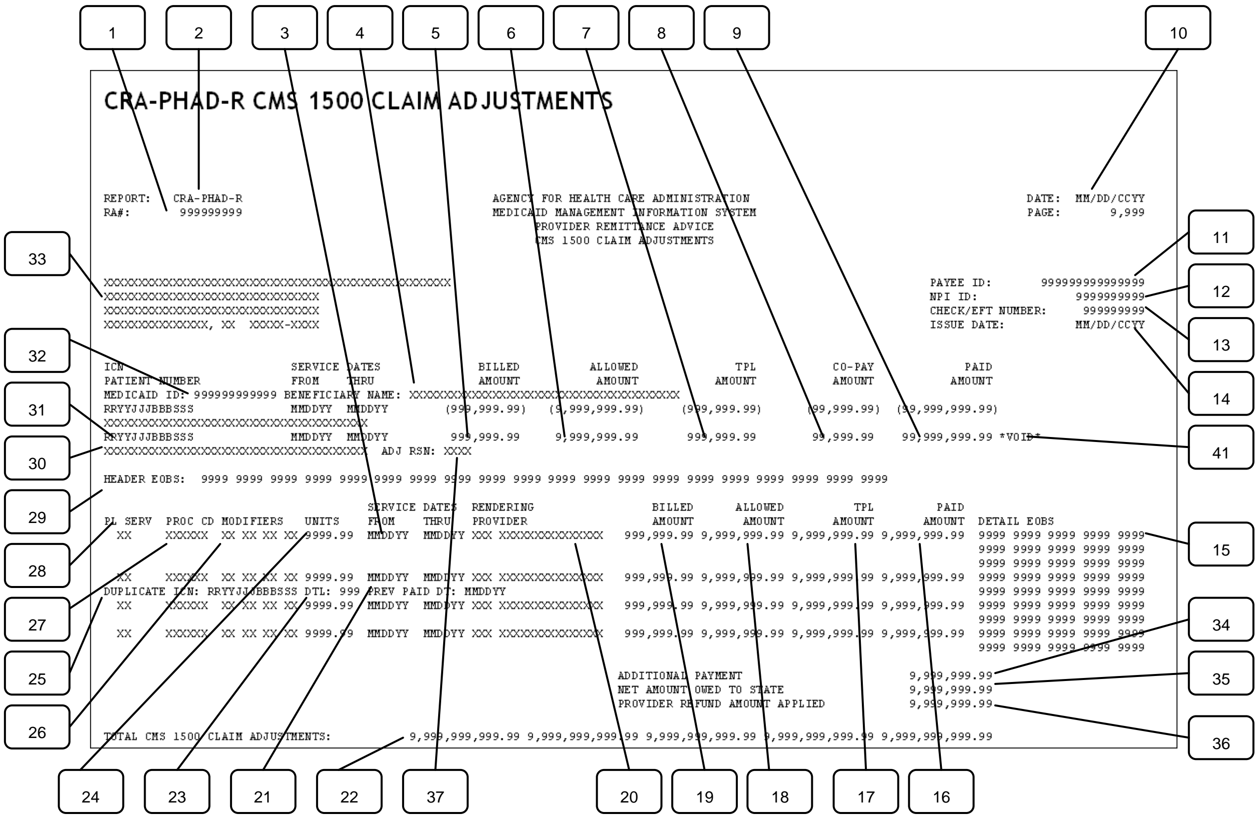
```
REPORT:   CRA-PHDN-R                          AGENCY FOR HEALTH CARE ADMINISTRATION                     DATE:  MM/DD/CCYY
RA#:       999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:       9,999
                                                    PROVIDER REMITTANCE ADVICE
                                                      CMS 1500 CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE ID:      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             NPI ID:             9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             CHECK/EFT NUMBER:    999999999
XXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                              ISSUE DATE:         MM/DD/CCYY

ICN                 SERVICE DATES                   BILLED            TPL    DUPLICATE        PREV
PATIENT NUMBER      FROM    THRU                    AMOUNT         AMOUNT    ICN              PAID DT
MEDICAID ID: 999999999999 BENEFICIARY NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS       MMDDYY  MMDDYY                999,999.99   9,999,999.99  RRYYJJJBBBSSS   MMDDYY
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                      SERVICE DATES  RENDERING                          BILLED          TPL
PL SERV  PROC CD MODIFIERS     UNITS  FROM    THRU   PROVIDER                           AMOUNT       AMOUNT  DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXXX   999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXXX   999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXXX   999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXXX   999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DT: MMDDYY                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXXX   999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DT: MMDDYY                                           9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL CMS 1500 CLAIMS DENIED:          9,999,999,999.99 9,999,999,999.99
```

Illustration 2-3. Sample CMS-1500 Claims in Process




```
CRA-PHSU-R CMS 1500 CLAIMS IN PROCESS

REPORT:    CRA-PHSU-R                          AGENCY FOR HEALTH CARE ADMINISTRATION                                DATE:  MM/DD/CCYY
RA#:        999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                               PAGE:       9,999
                                                     PROVIDER REMITTANCE ADVICE
                                                     CMS 1500 CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID:      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      NPI ID:             9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER:    999999999
XXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                       ISSUE DATE:         MM/DD/CCYY

ICN                 SERVICE DATES              BILLED                TPL
PATIENT NUMBER      FROM     THRU              AMOUNT                AMOUNT
MEDICAID ID: 999999999999 BENEFICIARY NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS       MMDDYY  MMDDYY         999,999.99       9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                      SERVICE DATES  RENDERING                   BILLED         TPL
PL SERV  PROC CD MODIFIERS     UNITS  FROM    THRU   PROVIDER                    AMOUNT         AMOUNT  DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX    999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX    999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX    999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX    999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99  MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX    999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL CMS 1500 CLAIMS IN PROCESS:    9,999,999,999.99   9,999,999,999.99
```

Illustration 2-4. Sample CMS-1500 Claim Adjustments




```
CRA-PHAD-R CMS 1500 CLAIM ADJUSTMENTS

REPORT:   CRA-PHAD-R                      AGENCY FOR HEALTH CARE ADMINISTRATION                    DATE:  MM/DD/CCYY
RA#:       999999999                      MEDICAID MANAGEMENT INFORMATION SYSTEM                   PAGE:       9,999
                                              PROVIDER REMITTANCE ADVICE
                                              CMS 1500 CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                         PAYEE ID:        999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                            NPI ID:               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                            CHECK/EFT NUMBER:      999999999
XXXXXXXXXXXXXX, XX  XXXXX-XXXX                                             ISSUE DATE:           MM/DD/CCYY

ICN                        SERVICE DATES          BILLED          ALLOWED            TPL          CO-PAY            PAID
PATIENT NUMBER             FROM    THRU           AMOUNT           AMOUNT         AMOUNT          AMOUNT          AMOUNT
MEDICAID ID: 999999999999 BENEFICIARY NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS              MMDDYY  MMDDYY     (999,999.99)   (9,999,999.99)   (999,999.99)    (99,999.99)  (99,999,999.99)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS              MMDDYY  MMDDYY       999,999.99     9,999,999.99     999,999.99      99,999.99    99,999,999.99 *VOID*
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  ADJ RSN: XXXX

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                       SERVICE DATES  RENDERING                   BILLED      ALLOWED          TPL         PAID
PL SERV  PROC CD MODIFIERS   UNITS     FROM    THRU   PROVIDER                    AMOUNT       AMOUNT       AMOUNT       AMOUNT  DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
                                                                                                                               9999 9999 9999 9999 9999
                                                                                                                               9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DT: MMDDYY                                                                     9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
                                                                                                                               9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999.99   MMDDYY  MMDDYY XXX XXXXXXXXXXXXXX   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999
                                                                                                                               9999 9999 9999 9999 9999

                                                                   ADDITIONAL PAYMENT                          9,999,999.99
                                                                   NET AMOUNT OWED TO STATE                    9,999,999.99
                                                                   PROVIDER REFUND AMOUNT APPLIED              9,999,999.99

TOTAL CMS 1500 CLAIM ADJUSTMENTS:    9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99
```

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
1	RA#	A unique identifier assigned to the remittance advice.
2	REPORT	A unique identifier for each of the nine claim types reporting claims in any of the four disposition categories of paid, denied, in process, or adjusted claims.
3	SERVICE DATE	The date the service was rendered; if multiple dates are billed the first date of service is the FROM date and the last date of service is the THRU date.
4	RECIPIENT NAME	The recipient's name as found on the Florida Medicaid eligibility file.
5	BILLED AMOUNT (header)	The total submitted claim charges from the claim.
6	ALLOWED AMOUNT (header)	The computed dollar amount allowable for the claim, arrived by adding up the individual detail allowed amounts.
7	TPL AMOUNT (detail)	The dollar amount paid by sources other than the state Medical Assistance Program being billed. If present, this amount is subtracted from the allowed amount.
8	CO-PAY AMOUNT	The dollar amount of recipient responsibility on a claim to be collected by the provider at the time the service is rendered. The header co-pay amount is arrived at by adding the detail co-pay amounts on all the detail lines from the claim, however, the detail co-pay does not display on the RA.
9	PAID AMOUNT (header)	The computed dollar amount paid for the claim, arrived by adding up the individual detail paid amounts.
10	DATE	Date the financial cycle began, e.g. Friday.
11	PAYEE ID	A unique identifier for the billing entity receiving payment or remittance activity. Applies to a provider or lien holder.
12	NPI ID	The National Provider ID number that is associated with the provider on the remittance advice.
13	CHECK or EFT NUMBER	If a check was generated, this is the check number corresponding to the check that was generated. If the provider is an EFT participant, this is the control number of the EFT transaction.

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
14	ISSUE DATE	The date the payment was issued.
15	DETAIL EOBS	Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of twenty EOB codes per detail line. These codes explain why a service was denied, payment was reduced, or why the claim is in process. At least one code is printed next to each claim line item reported on the remittance advice. A translation of these codes is included in the EOB Reason Code Section of the remittance advice.
16	PAID AMOUNT (detail)	The amount paid by Medicaid for the service billed by the provider.
17	TPL AMOUNT (header)	The computed TPL amount for the claim, arrived by adding up the individual detail TPL amounts.
18	ALLOWED AMOUNT (detail)	System calculated allowed amount for the service billed.
19	BILLED AMOUNT (detail)	The detail submitted claim charges from the claim.
20	RENDERING PROVIDER	The provider treating the patient and may or may not be part of a provider group practice. The three digits preceding the provider number will indicate if the number is NPI (National Provider Identifier) or MCD (Medicaid).
21	PREV PAID DT	When a claim is denied for duplicate reason(s), the paid date and the internal control number of the original paid claim are indicated for reference.
22	REMITTANCE TOTALS	The Summary Section is used to denote the total of all claims for the provider's remittance advice including Claims Data, Earnings Data, and Current Deductions
23	DTL	The number of the detail line that was a duplicate of the detail shown. This field is only shown when the claim detail was denied because there was a duplicate claim detail. If the entire claim denies, each detail number is not identified with this field, instead, the duplicate ICN and date will display in the header area of the RA.
24	UNITS	The units of service for the claim line item. This is the units of service for which the provider is to be paid.
25	DUPLICATE ICN	The ICN of the claim that was a duplicate of the claim shown. This field is only shown when the claim header or detail was denied because there was a duplicate claim header or detail.
26	MODIFIERS	Up to four alpha or numeric 2-digit codes added to the procedure code to clarify the services or procedures that are performed on the same calendar day.

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
27	PROC CD	The procedure code for the service billed and up to four modifiers.
28	PL SERVICE	A 2-digit place of service code placed on health care professional claims to indicate the setting in which a service was provided.
29	HEADER EOBS	Explanation of Benefits (EOB) codes that apply to the claim or adjustment header. These codes are used to explain how the claim or adjustment was processed or priced. There could be a maximum of twenty EOB codes. These codes explain why a service was denied, payment was reduced, or why the claim is in process. At least one code is printed next to each claim header item reported on the remittance advice. A translation of these codes is included in the EOB Reason Code Section of the remittance advice.
30	PATIENT NUMBER	The provider assigned patient account number if entered on the claim. This field will contain up to 38 characters.
31	ICN	Internal control number, the unique identifying number assigned to each claim submitted. The ICN is the primary number used to identify the claim in the system. The following explains the components that the 13 digits of the ICN represent: RR=Region Code CCJJJ=Year and Julian Date BBB=Batch Number SSS=Claim Sequence Note: See Appendix A for the Internal Control Number (ICN) Region Codes.
32	MEDICAID ID	The recipient's Medicaid identification number.
33	ADDRESS	The 'Mail To' address of the Payee displayed in the upper left corner of the remittance advice. This address could be different from the 'Home Office', 'Pay-To', or 'Service Location' address. The check is sent to the 'Pay-To' address.
34	ADDITIONAL PAYMENT	The amount paid to the provider, which is the difference between the original claims paid and the adjusted claims paid.
35	NET AMOUNT OWED TO STATE	The amount owed by the provider, which is the difference between the original claims paid and the adjusted claims paid.
36	PROVIDER REFUND AMOUNT APPLIED	The refund amount received from the provider and is listed under each applicable ICN.

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
37	ADJ RSN	The 4-digit adjustment reason code indicating the reason for adjusting the original claim. A translation of these codes is included in the EOB Reason Code Section of the remittance advice.
38	DATE SVC PERF	The date the service was rendered.
39	SURFACE	A code used to identify the tooth surface ID. Up to five surface IDs will be displayed.
40	TOOTH	A code used to identify the tooth ID. Up to two IDs will be displayed.
41	*V*	Voided claim indicator when the adjustment claim voids the original claim.
41	*VOID*	Voided claim indicator when the adjustment claim voids the original claim.
42	DISPENSE DATE	The date the pharmacy filled the prescription or provided pharmaceutical care.
44	METRIC QTY	Number of metric units of medication dispensed.
45	NDC	National Drug Code: an 11-digit number assigned by the Food and Drug Administration (FDA), which uniquely describes a product and its packaging.
46	NDC DESC	The description of the drug being dispensed.
47	RX NO.	The prescription number of the drug dispensed.
48	DUPLICATE HSID	The HSID of the claim that was a duplicate of the claim shown. This field is only shown when the claim header or detail was denied because there was a duplicate claim header or detail.
48	HSID	Health Service ID (HSID) is a unique number used to identify and track a claim processed through the First Health system.
49	ATTENDING PROVIDER	The provider treating the patient and may or may not be part of a provider group practice. The three digits preceding the provider number will indicate if the number is NPI (National Provider Identifier) or MCD (Medicaid).
50	REV CODE	The revenue code for the service billed.

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
51	LEVEL CARE	This is the level of care for Long Term Care situations where a recipient may need to be in an institution other than a hospital to receive certain services, such as skilled nursing, intermediate care, or developmentally disabled rehabilitation. 1 = Skilled 2 = Intermediate I 3 = Intermediate II 4 = State Mental Health Hospital 6 through 9 = ICF-DD Levels of Care H = AIDS Per Diem U = Skilled Fragile Children Under 21 X = Medicare Part A Coinsurance Payment
52	DAYS	Total number of days included in inpatient or long term care stay.
53	ADMIT DATE	Date of admission on inpatient claim.
54	MEDICARE DEDUCT (header)	The total amount paid by Medicaid on a claim applied towards the recipient's Medicare deductible.
55	MEDICARE BLOOD DEDUCT	The total amount of money paid towards the blood deductible on a Medicare Crossover claim.
56	MEDICARE CO-INS (detail)	The detail amount that the recipient should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.
57	MEDICARE ALLOWED AMT (header)	The total amount allowed by Medicare for all details on the claim.
58	MEDICARE PAID AMOUNT (header)	The total amount paid by Medicare for the services hospitalization stay.
59	MEDICAID TPL AMOUNT (header)	The total payments made by sources outside of the state Medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.

How to Read the Remittance Advice, continued

Field Title ID	**FIELD TITLE**	**FIELD TITLE DESCRIPTION**
60	MEDICAID CO-PAY AMOUNT (header)	The detail dollar amount of recipient responsibility on a claim that is to be collected by the provider at the time the service is rendered.
61	MEDICAID PAID AMOUNT (header)	The total dollar amount that is payable for the services or hospitalization stay.
62	MEDICAID BILLED AMOUNT (header)	The total dollar amount billed by the provider for the services or hospitalization stay.
63	MEDICAID BILLED AMOUNT (detail)	The detail dollar amount billed by the provider for the services or hospitalization stay.
64	MEDICAID PAID AMOUNT (detail)	The detail dollar amount that is payable for the services or hospitalization stay.
65	MEDICAID CO-PAY AMOUNT (detail)	The total amount that the recipient should pay and is deducted from the Medicare allowed amount to arrive at the Medicare paid amount.
66	MEDICAID TPL AMOUNT (detail)	The detail payment made by sources outside of the state Medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.
67	MEDICARE PAID (detail)	The detail amount paid by Medicare for the services or hospitalization stay.
68	MEDICARE ALLOWED (detail)	The detail amount allowed by Medicare.
69	MEDICARE CO-INS (header)	The total amount that the recipient should pay and is deducted from the Medicare allowed amount to arrive at the Medicare paid amount.
71	MEDICARE DEDUCT (detail)	The amount paid by Medicaid on a detail applied towards the recipient’s Medicare deductible.

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
72	FORM	On a Medicare Crossover, the value will be 'Inpatient' for Part A crossover claims and 'Outpatient' for Part C crossover claims.
73	PATIENT RESPONSIBILITY	The patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.
74	DAILY RATE	The per day rate for long term care.

How to Resubmit a Denied Claim

Instructions

Check the remittance advice before submitting a second request for payment. Claims may be resubmitted for one of the following reasons only:

- The claim has not appeared on a remittance advice as paid, denied, or suspended for thirty days after it was submitted; or
- The claim was denied due to incorrect or missing information or lack of a required attachment.

Do not resubmit a claim denied because of Medicaid program limitations or policy regulations. Computer edits ensure that it will be denied again.

Resubmitted claims must be original claims, not copies.

No Response Received

If the claim does not appear on a remittance advice within 30 days of the day the provider mailed it, the following steps should be taken:

- Check recently received remittance advice dates. Look for gaps. A remittance advice may have been mailed but lost in transit. If the provider believes this is the case, call the Medicaid fiscal agent, Provider Contact Center at 800-289-7799 and select Option 7.
- If there is not a gap in the dates of remittance advice received, please call the Medicaid fiscal agent, Provider Contact Center at 800-289-7799 and select Option 7. A representative will research the claim.
- If the fiscal agent advises that the claim was never received, please resubmit another claim immediately. See the Resubmission Checklist on the following page.

Note: See Requesting Help in Chapter 2 of the Florida Medicaid Provider General Handbook for additional information on obtaining assistance from the fiscal agent.

Correcting a Denied Claim

If the claim has denied for incorrect or missing information, correct the errors prior to resubmitting the claim.

New or Photocopied Claims

A void, adjustment, and AHCA priority exception claim may be resubmitted on a legible photocopy. An AHCA priority exception claim is a claim that AHCA sends to the Medicaid fiscal agent for processing. New claim forms must be used for all other types of resubmissions. Use correction tape to cover wrong information, and write the correct information on top of the tape in black ink. Attach requested documentation when resubmitting. Photocopies must contain an original signature and date. Do **not** use whiteout or highlight areas, as they cannot be imaged correctly. Claims and attachments that cannot be clearly imaged will be returned.

How to Resubmit a Denied Claim, continued

Resubmission Checklist

Use the following checklist to ensure that resubmittals are completed correctly before submitting.

- ❑ Did you wait thirty days after the original submittal before resubmitting a missing claim?
- ❑ If using a photocopy of a claim, did you make sure it was legible and properly aligned?
- ❑ If you chose to fill out a new claim, did you type or print the form in black ink? Are all multi-part copies legible?
- ❑ If you have corrected or changed the original claim form, have strikeovers been corrected on each copy? (Do not use whiteout.)
- ❑ Has the resubmitted claim been signed again and dated?
- ❑ Have you included all required attachments and documentation with the claim form?
- ❑ Is the claim clean of all highlighting and whiteout?
- ❑ Do you have the correct P.O. Box Number and corresponding nine-digit zip code for mailing the resubmitted claim? Resubmitted claims should be sent to the same P.O. Box as the original claim.
- ❑ Do you have any questions about resubmitted claims that are not answered in this handbook? If so, please contact the Medicaid fiscal agent, Provider Contact Center at 800-289-7799 and select Option 7.

Resolving an Incorrect Payment

Introduction

A provider who receives an incorrect payment for a claim or receives payment from a third party after Medicaid has made payment is required to submit an adjustment or a void to correct the payment.

Adjustment

An adjustment is needed if the correction to the payment would result in a partial refund or the claim was underpaid. Only paid claims can be adjusted.

Void

A void is needed if the correction to the payment would result in a complete refund of the Medicaid payment to the fiscal agent.

Resolving an Incorrect Payment, continued

All Claims Are Incorrect on the Remittance Advice

If a provider receives a payment for claims that the provider did not submit, the provider refunds the payment only when every claim payment listed on the remittance advice was paid to the provider in error.

If the payment was made by electronic funds transfer, the provider sends the Medicaid fiscal agent a check for the refund amount. Make the check payable to either "Florida Medicaid" or "Agency for Health Care Administration." If the incorrect payment was made by check, the provider returns the check to the Medicaid fiscal agent.

For example, none of the recipients listed on the remittance advice are the provider's patients. In this situation, return the remittance advice and check with a short note of explanation to:

Florida Medicaid
P.O. Box 14597
Tallahassee, Florida 32314-4597

Partially Incorrect Claims on the Remittance Advice

If the remittance advice contains some correct payments and some incorrect payments, do not return the check to the fiscal agent. Deposit the check and file a void request for each individual claim payment that should be completely refunded to Medicaid. File an adjustment request for each individual claim payment that was partially incorrect.

Voids may be performed electronically.

Incorrectly Billed or Keyed Claims

An adjustment or void request will be processed as a replacement to the original, incorrectly paid claim. All claim items on the request must be correctly completed. An adjustment or void must be for the entire amount, not just for remaining unpaid amounts or units.

For example, if a provider billed for and received payment for 3 units of a procedure and should have billed for 5 units, the provider must submit a claim for the full 5 units as an adjustment.

Adjustments for Keying Errors

If the claim denial was the result of a keying error, the provider can either:

- Call the fiscal agent at 800-289-7799, select Option 7, and request that the claim be reprocessed; or
- If one or more lines paid, follow the normal adjustment procedures.

The provider should check to be sure that a keying error caused the incorrect payment by comparing a copy of the originally submitted claim to the information on the remittance advice. In some cases, the claim payment must be reduced due to service limitations. If the maximum allowable amount according to the fee schedule was not paid, the remittance advice in the Adjustment Reason code column will specify the reason. All Adjustment Reason codes are translated at the end of the remittance advice just after the Summary Section.

Resolving an Incorrect Payment, continued

Third Party Recovery After Medicaid's Payment

If a provider receives payment from a third party after Medicaid paid the claim, the provider must submit an adjustment or void request.

- A void is required if another carrier's payment was equal to or higher than Medicaid's maximum allowable amount.
- An adjustment is required if the other carrier's payment was less than the Medicaid maximum allowable amount.

Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for information on filing adjustments to Medicare crossover claims.

How to File a Void Request on a Paper Claim

Requirements for Filing a Void Request

A void request will be processed as a replacement to the original, incorrectly paid claim. When a claim is voided, all the claim lines on the original claim are voided and the total payment for the claim is deducted.

There is no time limit on submitting a void.

The provider can submit a void request on the remittance advice, a legible photocopy of the original claim, an entirely new claim, or electronically.

Voiding Claims on the Remittance Advice

A claim can be voided by photocopying the remittance advice page and in black ink circling the claim to be voided. Write "void" on the side of the remittance advice page and briefly explain why the void is requested. Sign and date the remittance advice page in the margin. **Only one claim can be voided per copy of the remittance advice**. Additional claim voids require the submittal of additional photocopies of the remittance advice. Each remittance advice page can only have one claim circled on it.

Partially Incorrect Claim Lines on a Claim Form

If one claim line needs to be deleted from a claim when all other lines paid correctly, request an adjustment, not a void. If the request is marked as a void, all the claim lines will be recouped. To delete one line, in black ink mark the request an adjustment; cross out the line to be deleted; and write "delete" to the side of the line. Correct the total claim amount if appropriate.

How to File a Void Request on a Paper Claim, continued

Voiding Claims on a Paper Claim Form

When requesting a void, the provider must:

- Resubmit a photocopy of the original claim or a new claim form;
- Enter the items listed below;
- Initial and date the form if it is a photocopy, or sign and date the form if it is a new form; and
- Mail the void request to the fiscal agent for processing at:

  Adjustments and Voids
  P.O. Box 7080
  Tallahassee, Florida 32314-7080

CMS-1500	FORM ITEM	ACTION
1	**Void**	Enter a “V” for a void.
	Internal Control Number	Enter the most recently paid Internal Control Number (ICN) for the incorrectly paid claim. For a legacy claim that the prior Medicaid fiscal agent processed that has a 17-digit Transaction Control Number (TCN), enter the TCN. Enter the ICN or TCN assigned to the paid claim in the upper left corner, above the top line of the form. Be sure to enter all the digits correctly. Enter the most recent ICN or TCN for the claim. <u>Note</u>: See Appendix A for the Internal Control Number (ICN) Region Codes.
1a	**Recipient’s Medicaid ID No.**	If using a new claim form, enter the recipient’s ten-digit Medicaid ID Number. <u>Note</u>: See Chapter 3 in the Florida Medicaid Provider General Handbook for information on Medicaid ID numbers.
2	**Recipient’s Name**	If using a new claim form, enter the recipient’s last name, first name and middle initial exactly as it appears on the gold plastic Medicaid ID Card or other proof of eligibility.
31	**Authorized Signature and Title**	If using a new claim form, it must be signed. A photocopied form must be initialed and dated. The signature must be that of the provider, its employees or authorized billing agent.
31	**Billing Date**	If using a new claim form, it must be dated. Use the month, day, year format: MM/DD/YY. Example: 08/21/06 for August 21, 2006.
33	**Biller Provider Info & PH #**	If using a new claim form, enter the billing provider’s name, address, zip code plus 4, and telephone number.

***How To File A Void Request on a Paper Claim**, continued*

CMS-1500	FORM ITEM	ACTION
33a	**NPI**	If entering the pay to provider’s NPI, enter it in this field. If the rendering provider’s NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code ZZ and the taxonomy code in item 33b. If not entering the NPI, leave blank.
33b	**Other ID #**	If entering the pay to provider’s Medicaid provider number, enter it in this item preceded by the qualifier code 1D (qualifier code 1D stands for Medicaid provider number). If entering the pay to provider’s NPI in item 33a, and if the NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code. If the provider is a group provider, the group number must be entered and the individual treating provider number must be entered in item 24 J for each claim line billed.

On the following page is a sample void request form.

Illustration 2-5. Sample Void Request—CMS-1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA 22-08183-999-999 PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [V] TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 3334445556

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bates, Nancy A.

3. PATIENT'S BIRTH DATE MM DD YY: 04 13 1966 SEX M F [X]

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. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

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 [X] NO

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

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

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE: 01

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V22 . 1 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID 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	07 20 08		11		H1000		1	20.00	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.: NAB667789

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

28. TOTAL CHARGE $ 20.00

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

R.J. Smith, MD 08/15/08
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
R.J. Smith
1234 Medical Avenue
Anywhere FL 33333-44
a. NPI b. 1D050070900

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

How To File An Adjustment Request on a Paper Claim

Requirements for Filing an Adjustment

An adjustment request is processed as a replacement of the original, incorrectly paid claim. The original payment for the claim is completely deducted. All claim items on the request must be correctly completed. **An adjustment must be for the entire amount, not just for remaining unpaid amounts or units.** If a claim paid at "0" amount, it is considered a "paid" claim and must be adjusted.

A legible photocopy of the original claim or an entirely new claim can be used when submitting an adjustment.

The provider does not need to send an adjustment request for each claim line that paid incorrectly. All errors can be corrected with one adjustment request. Adjustments must be received by the Medicaid fiscal agent within one year of the date of payment.

Partially Incorrect Claim Lines on a CMS-1500 Claim Form

Use the following procedures when some claim lines on a CMS-1500 claim form paid correctly, and other lines did not pay correctly.

If some claim lines paid correctly and some lines were denied, do not request an adjustment. Cross out the claim lines that paid correctly, change the total amount billed, correct the errors on the lines that were denied, and resubmit the claim.

If all the claim lines paid, but some paid incorrectly, request an adjustment. Make needed corrections and circle the items to be corrected in black ink. Do not cross out the lines that paid correctly. Crossed-out lines are treated as voids and payment for these lines will be recouped.

If one claim line needs to be deleted from a claim that has other lines that paid correctly, request an adjustment, not a void. If the request is marked as a void, all the claim lines will be recouped. To delete one line, mark the request as an adjustment, circle the line to be deleted, and write "delete" to the side of the line.

How To File An Adjustment Request on a Paper Claim, continued

Adjustment Instructions

When requesting an adjustment, the provider must:

- Resubmit a photocopy of the original claim or a new claim form;
- Enter the items listed below;
- Ensure that the items on the adjusted claim match the items on the original claim, except for the corrections that are made and circled in black ink;
- Initial and date the form if it is a photocopy, or sign and date it if it is a new form;
- Attach copies of the documents that were required for the original claim to the adjustment request; and
- Mail the adjustment request to the fiscal agent for processing at:

  Adjustments and Voids
  P.O. Box 7080
  Tallahassee, Florida 32314-7080

CMS 1500	TITLE	ACTION
1	**Adjustment**	Enter an "A" for an adjustment in the block at the top of the form
	Internal Control Number	Enter the most recently paid Internal Control Number (ICN) for the incorrectly paid claim. For a legacy claim that the prior Medicaid fiscal agent processed that has a 17-digit Transaction Control Number (TCN), enter the TCN. On the CMS-1500, enter the ICN or TCN in the upper left corner, above the top line of the form. Be sure to enter all the digits correctly. Enter the most recent paid ICN or TCN for the claim. Note: See Appendix A for the Internal Control Number Region Codes.
1a	**Recipient's Medicaid ID No.**	If using a new claim form, enter the recipient's ten-digit Medicaid ID Number. The fiscal agent cannot change the recipient's ID number on an adjustment. If the recipient's ID number was incorrect on the original claim, request a void and resubmit the claim with the correct number after the void appears on the remittance Advice. Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for information on Medicaid ID numbers.
2	**Recipient's Name**	If using a new claim form, enter the recipient's last name, first name and middle initial exactly as it appears on the gold plastic Medicaid ID Card or other proof of eligibility.

How To File An Adjustment Request on a Paper Claim, continued

CMS 1500	TITLE	ACTION
3-29	**Patient's Birth Date through Amount Paid**	Correct any errors or add missing information that caused the incorrect payment. For example, wrong number of units, incorrect billed amount, or wrong procedure code. Circle the corrected information in black ink. a. If the error was because the fiscal agent incorrectly keyed the item(s) and the claim is correct, no correction is necessary to the original claim. However, the provider must circle the item that was incorrect in black ink. (The remittance advice is the record of what was keyed.) b. Do not record previous Medicaid payments on the claim form for adjustment requests. The provider may attach a photocopy of the remittance advice to the adjustment request, with the incorrectly paid claim(s) circled in black ink. This is optional.
31	**Authorized Signature and Title**	If using a new claim form, it must be signed. The signature must be that of the provider, its employees or authorized billing agent. A photocopied form must be initialed and dated.
31	**Billing Date**	If using a new claim form, it must be dated. Use the month, day, year format: MM/DD/YY. Example: 08/21/08 for August 21, 2008
33	**Biller Provider Info & PH #**	If using a new claim form, enter the billing provider's name, address, zip code plus 4, and telephone number.
33a	**NPI**	If entering the pay to provider's NPI, enter it in this field. If the rendering provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code ZZ and the taxonomy code in item 33b. If not entering the NPI, leave blank.
33b	**Other ID #**	If entering the pay-to provider's Medicaid provider number, enter it in this item preceded by the qualifier code 1D (qualifier code 1D stands for Medicaid provider number). . If entering the pay to provider's NPI in item 33a, and if the NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code. If the provider is a group provider, the group number must be entered and the individual treating provider number must be entered in item 24 J for each claim line billed.

On the following page is a sample adjustment request form.

Illustration 2-6. Sample Adjustment Request--CMS-1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA 22-08183-999-999 PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [A] TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) 4445556673

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hernandez, Kay

3. PATIENT'S BIRTH DATE MM DD YY 07 07 1957 SEX M [ ] F [X]

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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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 [X]

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

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

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE 01

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V22 . 1
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID 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	07 02 08		11		H1000		1	~~20.00~~	1	F	NPI	
2								40.00 clerical			NPI	
3								error, please adjust			NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. HE47893

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

28. TOTAL CHARGE $ 40.00 ~~20.00~~

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

A. Goodhill, MD 10/02/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

A. Goodhill
111 Surgeaon Road
Someplace FL 33333-4444

a. 0123456789 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Identifying Adjustments and Voids on the Remittance Advice

Adjustments on the Remittance Advice

Adjustment requests are printed on the remittance advice as two different claim entries.

The incorrectly paid claim is listed exactly as it was when it was originally reported. The Internal control number (ICN) for this entry is the same as the original claim. The original incorrect payment is credited back to Medicaid's account. A minus symbol (-) appears just to the right of the incorrectly paid amount. A negative number is notated in the format (#######).

The adjusted request is printed directly following the original claim entry. Incorrect claim information on the original now shows as corrected. The difference between these two entries in the "NET" amount on the remittance advice.

An Adjustment Reason Code (ADJ-R) and the ICN of the claim being adjusted are listed following the two claim entries. Adjustment reason codes are defined in the summary section of the remittance advice.

Note: See Appendix A for the Internal Control Number (ICN) Region Codes.

Voids on the RA

Void requests are printed as one claim entry. The entire claim is displayed and the payment amount is returned to Medicaid. A minus symbol (-) appears next to the amount. A negative number is notated in the format (#######).

Payment Increase or Deduction Due to an Adjustment

When a claim is adjusted, the net amount of payment is added to or deducted from the provider's payment for the current claims cycle. If the adjustment or void results in a deduction against a zero or insufficient balance for the current claims cycle, the balance will be carried over to the next claims cycle.

Adjustment or Void Reason Codes

An Adjustment Reason Code appears with each adjustment or void shown on the remittance advice. These numeric codes are explained on the remittance advice.

Electronically submitted adjustments will always indicate adjustment code "79."

Billing Medicaid When There is a Third Party Liability Discount Contract

Benefits Under Discounted Contracts

When the provider enters into a plan with a third party in which the provider agrees to accept as full payment an amount less than its customary charges, Medicaid will reimburse the claim only to the extent that there remains a patient liability under the plan, such as a copayment or deductible. The third party payment plus the Medicaid payment cannot exceed the Medicaid maximum fee for the service.

Procedures for Billing Medicaid When there is a Discount Contract

If the discount contract's allowable is less than Medicaid's maximum allowable fee and there remains a patient liability under the plan, use the following procedures to obtain Medicaid reimbursement:

1. Compute the amount of patient responsibility (deductible, coinsurance, etc.).
2. Deduct this amount from the Medicaid rate.
3. Show the resulting amount as the third party payment in the shaded area of Items 24 F. Enter the identifier IP for Individual Policy or GP for Group Policy in the shaded area of item 24 F.

If the Explanation of Benefits (EOB) from the insurance company is not itemized, prorate the discount contract's allowable, third party liability payment and the patient responsibility for each line item.

Following are examples of a claim and EOB.

Illustration 2-7. Example of a CMS-1500 with Contractual Third Party Payment When the Contracted Payment Rate is Less Than the Medicaid Maximum Fee

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Florida, Resident A.

3. PATIENT'S BIRTH DATE (MM DD YY): 08 28 1993 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Florida, Resident A.

5. PATIENT'S ADDRESS (No., Street): 119 Home Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 119 Home Street

CITY: Hillard STATE: FL

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Hillard STATE: FL

ZIP CODE: 32046 TELEPHONE (Include Area Code): (904) 999-9999

ZIP CODE: 32046 TELEPHONE (Include Area Code): (904) 999-9999

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Florida, Resident A.

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 9494949494

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): 08 28 1993 SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State): N

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ACS

d. INSURANCE PLAN NAME OR PROGRAM NAME: Happy Insurance

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ___ DATE ___

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ___

14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YY) TO (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE: 01

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 465.9
2. 599.0
3. 462.0
4. 463.0

22. MEDICAID 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	02 28 07	02 28 07	11	1	99212		1,2	GP 18.89 30.00	1		NPI	
2	03 08 07	03 08 07	11	1	99212		2	GP 18.89 30.00	1		NPI	
3	04 16 07	04 16 07	11	1	99212		3	GP 18.89 30.00	1		NPI	
4	04 16 07	04 16 07	11	1	86403		3	GP 9.89 15.00	1		NPI	
5	04 20 07	04 20 07	11	1	99212		4	GP 18.89 30.00	1		NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 999-99-9999 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: A1593237

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

28. TOTAL CHARGE: $ 135.00

29. AMOUNT PAID: $ 85.45

30. BALANCE DUE: $

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.)

John Smith, MD 04/21/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Doctor
444 PayMe Street
Anywhere FL 33333-4444

a. NPI b. 1D123456700

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Illustration 2-8. Example of an Explanation of Benefits when the Contracted Payment Rate is Less Than the Medicaid Maximum Fee

EXPLANATION OF BENEFITS

Happy Insurance
121 TPL Street
Everywhere, FL 99999

NAME/ID
FLORIDA, RESIDENT A.
PATIENT NO. A1593237

PARTICIPATING EMPLOYER
YUMY SEAFOODS, INC
GROUP NO. 1919I

DATE: 06/01/03

ABC Doctor
444 Payment Street
Anywhere, FL 33333

DATES OF SERVICE-PROVIDER/SERVICE	AMOUNT CHARGED	AMOUNT INELIGIBLE	DISCOUNT	AMOUNT COVERED	ENCOUNTER FEE	DEDUCTIBLE	COINSURANCE	BENEFIT
02/28--05/20/03: ABC Doctor Physician	95.00			95.00		5.00	5.00	85.00
02/28—05/20/03: ABC Doctor Physician Discount	40.00		40.00					
TOTALS	135.00	0.00	40.00	95.00	0.00	5.00	5.00	85.00
						OTHER COVERAGE		0.00
						ADJUSTMENTS		0.00
						AMOUNT OF PAYMENT		85.00

HAPPY INSURANCE

Illustration 2-9. Example of a Pay in Full Service Contract

PAY IN FULL SERVICE CONTRACTS
(PRORATED)

TP Payment =	Total TP Payment divided by total DRG/Contract Fee Schedule ($85.00/135.00=.63)		
Patient Responsibility =	Total Patient Responsibility divided by total DRG/Contract Fee Schedule ($10.00/135.00=.07)		
Contracts Allowable =	Total Contracts Allowable (TP payment plus patient responsibility) divided by total DRG/Contract Fee Schedule ($95.00/135.00=.70)		
Line 1	DRG/Contract Fee Schedule		$30.00
	Patient Responsibility	.07%	$ 2.22
	TP Payment	63%	$18.89
	Contracts Allowable	70%	$21.11
	Medicaid Allowable		$21.00

24F (shaded area)=Since the Contract's Allowable is more than Medicaid's Allowable, use normal billing Procedures ($18.89)

Line 4	DRG/Contract Fee Schedule		$15.00
	Patient Responsibility	07%	$ 1.11
	TP Payment	63%	$ 9.44
	Contracts Allowable	70%	$10.56
	Medicaid Allowable		$11.00

24F (shaded area)=An amount subtracted from Medicaid Allowable leaving the Patient's Responsibility ($11.00-1.11=9.89) (The Contract's Allowable is less than Medicaid's Allowable)

CHAPTER 3
ADDITIONAL FILING REQUIREMENTS

Overview

Introduction

This chapter describes the time limit for submission of a claim, prior authorization, out-of-state claims, Medically Needy recipient claims, and other special forms.

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Prior Authorization Requirements

Introduction

In order to be reimbursed by Medicaid, certain services require that providers obtain prior authorization of the services' medical necessity per 59G-1.010 (166), F.A.C., before the services are performed.

Non-Institutional Programs with Services that Require Prior Authorization

The following non-institutional Medicaid programs require prior authorization for certain procedure codes and exceptions to service limitations:

- Advanced Registered Nurse Practitioner
- Ambulance, Land and Air
- Chiropractic
- Community Behavioral Health
- Dental
- Durable Medical Equipment
- Hearing
- Home Health
- Independent Laboratory Services
- Medical Foster Care
- Optometric
- Pharmacy
- Physician
- Physician Assistant
- Podiatry
- Prescribed Pediatric Extended Care Centers (PPECs)
- Registered Nurse First Assistant
- Visual

Note: See the service-specific Coverage and Limitations Handbooks and the Medicaid Provider Reimbursement Schedules for services and services limitation exceptions that require prior authorization. The handbooks and reimbursement schedules are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks or Fee Schedules. The handbooks are incorporated by reference in the service-specific rules in Chapter 59G-4, Medicaid Services, F.A.C. The Medicaid Provider Reimbursement Schedules are incorporated by reference in 59G-4.002, F.A.C.

Prior Authorization Requirements, continued

Hospital Services that Require Prior Authorization

The following hospital services require prior authorization:

- Inpatient admissions for psychiatric and substance abuse.
- Inpatient admissions for medical, surgical, delivery and rehabilitation services, except for the exemptions noted in this chapter.
- Adult heart, liver, and out-of-state transplants.
- Referrals to out-of-state facilities.

Note: See Authorization for Inpatient Hospital Admissions and Prior Authorizations for Inpatient Psychiatric and Substance Abuse Services in this chapter for the authorization procedures for these services.

MediPass Referrals

If the service is covered under MediPass, the provider must obtain a MediPass referral in addition to Medicaid prior authorization.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on MediPass.

Medicare Crossovers

Medicare crossover claims do not require prior authorization.

Who Submits the Request

The request for prior authorization must be submitted by the provider who plans to furnish a service, except for out-of-state prior authorization.

Note: See Prior Authorization for Out-of-State Services in this chapter for the procedures for out-of-state services.

Where To Submit Prior Authorization Requests

Except for the services listed on the following pages, submit paper prior authorization requests to:

Florida Medicaid—Prior Authorization
P.O. Box 7090
Tallahassee, Florida 32314-7090

Prior Authorization Requirements, continued

Ambulance Prior Authorization Requests

Ambulance providers obtain authorization from the area Medicaid offices. They do not use the Authorization Request Form that is in this chapter.

Note: See Prior Authorization for Ambulance Services in Chapter 2 in the Florida Medicaid Ambulance Transportation Services Coverage and Limitations Handbook for authorization instructions. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.015, F.A.C.

Durable Medical Equipment Prior Authorization Requests

Durable Medical Equipment prior authorization requests for the following items must be submitted directly to the recipient's area Medicaid office:

- Modifications and substantial repairs to custom wheelchairs;
- Non-custom motorized or powered wheelchairs;
- Power operated vehicles; and
- Replacement wheelchair components and accessories that are listed on the DME fee schedule as requiring prior authorization.

Durable Medical Equipment prior authorization requests for custom manual and custom power-operated wheelchairs must be submitted directly to the Medicaid headquarters at following address for review:

Bureau of Medicaid Services
DME Prior Authorization
2727 Mahan Drive, Mail Stop 20
Tallahassee, FL 32308

Durable Medical Equipment prior authorization requests for hospital bed procedure codes E0250, E0255 and E0303 and miscellaneous durable medical equipment procedure code E1399 must be submitted directly to the fiscal agent at:

Florida Medicaid—Prior Authorization
P.O. Box 7090
Tallahassee, Florida 32314-7090

Note: The area Medicaid offices' addresses and phone numbers are available on AHCA's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-5.020, F.A.C.

Prior Authorization Requirements, continued

Durable Medical Equipment Prior Authorization Requests (continued)

Note: The Durable Medical Equipment and Medical Supply Services Provider Fee Schedules are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Fee Schedules. They are incorporated by reference in 59G-4.071, F.A.C.

Note: See Chapter 2 in the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on the services that require authorization. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.070, F.A.C.

Organ Transplant Authorization Requests

Medicaid designated organ transplant centers must submit requests for out-of-state transplants or adult heart and liver transplants to:

Medicaid Transplant Coordinator
2727 Mahan Drive, Mail Stop 20
Tallahassee, FL 32308

Note: See Organ and Bone Marrow Transplant Services in Chapter 2 of the Florida Medicaid Physician Services Coverage and Limitations Handbook for additional instructions. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.230, F.A.C.

Prior Authorization Requirements, continued

Medical Foster Care and Prescribed Pediatric Extended Care Center Requests

Medical Foster Care and Prescribed Pediatric Extended Care Center prior authorization requests are sent directly to the recipient's area Medicaid office.

Note: The area Medicaid offices' addresses and phone numbers are available on AHCA's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-5.020, F.A.C.

Note: See Chapter 2 in the Florida Medicaid Medical Foster Care Coverage and Limitations Handbook and Chapter 2 in Prescribed Pediatric Extended Care Center Services Coverage and Limitations Handbook for additional instructions. The handbooks are available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Medical Foster Care Coverage and Limitations Handbook is incorporated by reference in 59G-4.197, F.A.C. The Prescribed Pediatric Extended Care Center Services Coverage and Limitations Handbook is incorporated by reference in 59G-4.260, F.A.C.

Pre-certification for Home Health Services

For the home health pre-certification process for visits that exceed the service limitations, see Chapter 2 of the Florida Medicaid Home Health Services Coverage and Limitations Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.130, F.A.C.

How Requests Are Processed

The fiscal agent receives the authorization request and enters it onto the Florida Medicaid Management Information System (FMMIS) as a pended request. The Medicaid fiscal agent forwards the request and its attachments to Medicaid medical consultants, who review the request for medical necessity and approve or deny it. The prior authorization request may take several weeks to process, so a provider should submit the request as soon as the need for the service is identified.

Prior Authorization Requirements, continued

Decision Notification

The Medicaid fiscal agent or Medicaid contracted authorization authority notifies the provider with a letter of approval or denial.

If there is insufficient information to make a decision regarding the prior authorization, the provider will be notified to send additional information.

Denied Requests

If the prior authorization is denied, the provider who submitted the request is notified and a copy of the notification is sent to the recipient stating the reason for the denial and giving the recipient notice of the right to appeal the decision.

The recipient appeals the decision to the area Medicaid office. The area Medicaid office will forward the request to the Department of Children and Families, Office of Appeal Hearings. Their hearing officers conduct appeal hearings for Medicaid recipients for authorization of services.

Approved Requests

Prior authorizations, except for dental, pharmacy and organ and bone marrow transplants, are valid for 120 days from the posted date of approval, and can be extended upon written request of the provider.

The approval letter contains a prior authorization number for billing and reference.

An approved authorization is not a guarantee that Medicaid will reimburse the service. Both the provider and recipient must be eligible on the date of service, the service must not have exceeded any applicable service limits, and a clean claim must be submitted within the time limit for submitting claims.

Note: See Chapter 1 for information on the time limit for submitting claims.

Note: See Prior Authorization for Medically Needy Recipients for information on a Medically Needy recipient who is not eligible for Medicaid when the prior authorization decision is received.

Prior Authorization Requirements, continued

Submission of a Prior Authorization Claim for Payment

Providers should submit a claim for payment for a prior authorized service immediately after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the prior authorization number in item 23 on the claim form.

Note: See Chapter 1 in this handbook for additional information on completing the claim form.

Extension of the Authorization

If the Medicaid prior authorized service cannot be furnished within 120 days, or one year for organ transplant services, the provider may request an extension by writing to the Prior Authorization Unit at the following address:

Bureau of Medicaid Services
Medicaid Prior Authorization Unit
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

The letter must give the medical reason for the extension request beyond the original 120 day prior authorization period.

Medicaid Authorization Request Form

How to Request Authorization

Providers request prior authorization by submitting a PA 01, Florida Medicaid Authorization Request Form, as described below.

The PA 01 Request Form

A prior authorization request must be submitted on the PA 01 Form, 07/08, Florida Medicaid Authorization Request, by all providers, except ambulance, dentists, and pharmacists, to request prior or post authorization for all prior authorized services except inpatient hospital admissions and psychiatric admissions.

Note: PA 01 Form, Florida Medicaid Authorization Request, can be obtained from the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Forms. It is incorporated by reference in 59G-4.001, F.A.C.

Medical Documentation

Supporting medical documentation that explains the medical necessity of the service to be provided or justification of emergency treatment, if prior authorization was not obtained, must be attached to the PA 01 form.

Medical documentation includes at a minimum:

- Current history and physical;
- Surgical and anesthesia risk factors;
- Laboratory results, if appropriate;
- Radiology reports, if appropriate; and
- Any other diagnostic test results to support the medical necessity for the medical and surgical services requested.

Note: See Organ and Bone Marrow Transplant Services in Chapter 2 of the Physician Services Coverage and Limitations Handbook for required medical documentation for prior authorization for organ transplant services.

Form Completion

Any items left incomplete on the PA 01 form will result in the form being returned to the requesting provider for completion. The prior authorization request cannot be completed by Medicaid staff or the Medicaid fiscal agent.

Recipient identifiers such as name, date of birth, Medicaid identification number must match those of the supporting medical documentation supplied with the PA 01 request form

Instructions for Prior Authorization Form Completion

A copy of the PA 01 form, step-by-step instructions and a review checklist are on the following pages.

Illustration 3-1 Sample Medicaid Authorization Request – PA 01

Return to:
P.O. BOX 7090,
TALLAHASSEE, FL 32314-7090

STATE OF FLORIDA
FLORIDA MEDICAID
AUTHORIZATION REQUEST

0 5 0 0

Please check box:

Hospital
❑ Prior Authorization
❑ Post Authorization

Physician
❑ Prior Authorization
❑ Post Authorization

❑ **Other** (excludes dental)
Post Authorization Date of Service: ______

I. General Information

Recip. Number- 10 digits	Last Name	First Name	Date of Birth

Diagnosis	Procedure Code	Procedure Description	Quantity

EXPLANATION OF NECESSITY FOR PROCEDURES (Attach supportive x-rays, lab reports, operative notes, and discharge summaries etc. if indicated)

II. PROVIDER INFORMATION

Medicaid Provider Number: ______

I certify that the information given in this form is a true and accurate medical indication for the procedures requested. All other treatment to correct this problem has been exhausted.

______ Signature of Provider ______ Date

Provider Name: ______
Address: ______

Contact Name: ______
Contact Phone Number: ______

AGENCY USE ONLY:

Approved ❑ Date: ______
P.A. Number ______
Proc. Code ______
Amount ______

Denied ❑ Reason ______

Additional Info. ❑ Specify: ______

Reviewed by:

______ Signature ______ Date

Approved authorizations do not guarantee payment, but are contingent upon recipient and provider *Eligibility* on the *Date of Service*, and services being provided not more than 120 days from the date of authorization.

PA 01 07/08

Incorporated by reference in 59G-4.001, F.A.C.

Medicaid Authorization Request Form, continued

TITLE	ACTION
Provider Authorization Type	Check the type of authorization required under the appropriate provider type. Hospital______________ Physician_________________ Chiropractic providers must mark the prior authorization block under physician, check the block marked "Other," and type "Chiropractic" above the "Other" box. Do not indicate **Post Authorization** unless you have already provided the service in an emergency situation. Medical documentation must be attached supporting the emergency nature of the service provided and the reason a prior authorization could not be obtained prior to rendering the service.
Post Authorization Date of Service	Complete this block only for a service that requires post authorization. Enter the date the service was rendered in MM/DD/YY format. (Example: 02/10/06 for February 10, 2006) Community mental health providers cannot obtain post authorization.
Recip. Number	Enter the recipient's 10-digit Medicaid identification number. Do not leave blank. If you do not know the recipient's Medicaid identification number, enter the recipient's social security number or card control number from the front of the recipient's Medicaid identification card.
Last Name	Enter the recipient's last name exactly as it appears on the Medicaid Identification Card or other eligibility document.
First Name	Enter the recipient's first name exactly as it appears on the Medicaid Identification Card or other eligibility document.
Date of Birth	Enter the recipient's birth date in MM/DD/YY format. (Example: 08/21/88 for August 21, 1988.)
Diagnosis	Enter the complete ICD-9-CM diagnosis code and a description of the diagnosis. If not entered, the prior authorization will be returned to the requesting provider to be completed.
Procedure Code	Enter the appropriate procedure code from either of the Fee Schedule Appendix in the service-specific Coverage and Limitations Handbook or the Fee Schedules on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Fee Schedules. If not entered, the prior authorization will be returned to the requesting provider to be completed.

Medicaid Authorization Request Form, continued

TITLE	ACTION
Procedure Description	Enter a description of the operation, procedure, treatment or service for which authorization is requested. Do not leave blank. You may enter "see attached medical documentation" only if attached documentation is supplied at the time of submission. If left blank, the form will be returned for completion. Note: See Medical Documentation in this section for more information.
Quantity	Enter a number to indicate the quantity (units of service) requested, if applicable.
Explanation of Necessity for Procedures	Enter a specific explanation of the necessity for the procedure. Attach documentation to substantiate medical necessity, such as x-rays, lab reports, operative reports, and admission and discharge summaries. Community mental health providers must attach a copy of a signed and dated treatment plan, indicating and justifying the medical need for services in excess of the established limits. The plan must be current, must cover the type of services requested, and must state the time period the services are needed.
Provider Number	Enter the nine-digit Florida Medicaid provider identification number. Do not enter the National Provider Identifier (NPI). If the requesting provider is not an enrolled Medicaid provider, reimbursement is not available to the requesting provider unless he enrolls in the Medicaid program. All other providers, such as anesthesiologists, assistant surgeons or ancillary-enrolled Medicaid providers assisting with the services must request their own prior authorization for the service for reimbursement.
Provider's Signature and Date	Sign the PA 01 form and enter the date the form was signed.
Provider Name and Address	Enter the provider's name, address and telephone number. If the prior authorization is submitted for an out-of-state service, provide the name, address and telephone number of the out-of-state provider for the service requested.
Contact Name and Contact Phone Number	Enter the name and phone number for the person who Medicaid should contact if there are any questions about the prior authorization request.
Office Use Only	No entry required.
Completed PA 01 Request Form	A sample of a completed PA 01 form is on the following page.

Illustration 3-2. Sample Medicaid Authorization Request – PA 01

Return to:
P.O. BOX 7090,
TALLAHASSEE, FL 32314-7090

STATE OF FLORIDA
FLORIDA MEDICAID
AUTHORIZATION REQUEST

0 5 0 0

Please check box:

Hospital
- ❑ Prior Authorization
- ❑ Post Authorization

Physician
- ❑ Prior Authorization
- ❑ Post Authorization

☒ **Other** (excludes dental)
Post Authorization Date of Service: ______

I. General Information

Recip. Number- 10 digits	Last Name	First Name	Date of Birth
1234567890	Doe	Jane	11/23/55

Diagnosis 389.10	Procedure Code	Procedure Description	Quantity
Conductive Hearing Loss	V5050/V5090/V5264	Cat. II Hearing Aid/Fitting Fee/Earmold	1 each

EXPLANATION OF NECESSITY FOR PROCEDURES (Attach supportive x-rays, lab reports, operative notes, and discharge summaries etc. if indicated)

51 year old female with a conductive (severe to moderate) hearing loss in both ears whose left hearing aid was damaged beyond repair. She is experiencing difficulties with communication, which are adversely affecting her employment.

(audiogram attached)

II. PROVIDER INFORMATION

Medicaid Provider Number: 9876543210

I certify that the information given in this form is a true and accurate medical indication for the procedures requested. All other treatment to correct this problem has been exhausted.

John Smith, AUD, CCCA — Signature of Provider
8/05/08 — Date

Provider Name: Audiology Associates
Address: 123 Main Street
Anytown FL 30323

Contact Name: John Smith
Contact Phone Number: 850-234-5678

AGENCY USE ONLY:

Approved ❑ Date: ______
P.A. Number ______
Proc. Code ______
Amount ______

Denied ❑ Reason ______

Additional Info. ❑ Specify: ______

Reviewed by:

Signature ______ Date ______

Approved authorizations do not guarantee payment, but are contingent upon recipient and provider *Eligibility* on the *Date of Service*, and services being provided not more than 120 days from the date of authorization.

PA 01 07/08

Checklist for the Medicaid Authorization Request Form

Introduction

The purpose of this checklist is to provide instructions for completion of the PA-01 form, Florida Medicaid Authorization Request. Providers should check each block to make sure that all items are entered correctly. Proper completion of the form will help avoid unnecessary delays in the processing of the prior authorization request.

1. Enter type of authorization required under the appropriate provider type.
2. For post authorization, enter date of service. Complete if an emergency service was provided or for retroactive eligibility.
3. Enter the recipient's Medicaid ID number.
4. Enter the recipient's last name.
5. Enter the recipient's first name.
6. Enter recipient's date of birth: MM/DD/YY.
7. Enter the diagnosis from ICD-9-CM diagnosis code book and a description of the diagnosis.
8. Enter the appropriate procedure code.
9. Enter a description of the procedure for which authorization is requested.
10. Enter number to indicate quantity (units of service) requested.
11. Enter specific explanation referring to the necessity for the procedure. Attach supportive summaries if necessary (operative reports, admission and discharge dates, lab reports, X-rays, treatment plans).
12. Enter Florida Medicaid provider number. Do not enter the National Provider Identifier.
13. The attending physician signs and dates the authorization request.
14. Enter provider's name and address, contact name, and contact phone number.
15. OFFICE USE ONLY: NO ENTRY REQUIRED.

Prior Authorization for Medically Needy Recipients

Introduction

A Medically Needy recipient is an individual who would qualify for Medicaid except that the individual's income or resources exceed Medicaid's income or resource limits.

On a month-by-month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month, depending on the date the medical expenses were incurred.

Note: For information on an individual recipient's share of cost, please call the Department of Children and Families (DCF) ACCESS number 866-762-2237.

Circumstance Requiring Prior Authorization

Because obtaining a decision on a prior authorization request takes more than one month, a Medically Needy recipient may not be eligible for Medicaid when the prior authorization decision is received.

If the recipient is not eligible and the provider performs the procedure and bills the recipient, the recipient's medical expense may make the recipient eligible for the month. The provider may then be reimbursed by Medicaid for the prior authorized procedure. However, the provider must obtain the prior authorization before rendering the service.

In order to ensure that the provider may be reimbursed if the recipient is eligible or becomes eligible for Medicaid in the month the procedure is rendered, the provider must follow the steps described in the following information blocks

Medical Documentation

The provider must complete a PA 01 form, Florida Medicaid Authorization Request Form, and attach a cover letter explaining that it is for a Medically Needy recipient. The provider must send a cover letter, the PA 01 form, and other documents that support the need for the service, such as treatment plans, medical reports, office notes, and test results, to the recipient's area Medicaid office.

The area Medicaid office will review the information for completeness and forward it to the headquarters Medicaid office.

Note: The area Medicaid offices' addresses and phone numbers are available on AHCA's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also in Appendix A of the Florida Medicaid Provider General Handbook. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-5.020, F.A.C.

Prior Authorization for Medically Needy Recipients, continued

State Medicaid Consultant Review

A state Medicaid consultant will review the request and approve or deny it. Approval of the request is based on the medical necessity of the procedure being performed.

Approval by a state Medicaid consultant is not a guarantee of Medicaid reimbursement. The provider and the recipient must be eligible on the date of service, and the service must not exceed applicable service limitations.

Notification of Approval or Denial

The headquarters Medicaid office will notify the area Medicaid office by telephone of the consultant's decision. The area Medicaid office will then notify the provider by telephone.

Scheduling and Billing the Procedure

Once the procedure is approved, the provider can schedule and perform the service and bill the recipient as a private paying patient. The recipient or provider must send the bill to the DCF eligibility specialist to determine if the recipient meets his share of cost requirement and is eligible for Medicaid for the month in which the service was rendered.

Establishing Eligibility

The eligibility specialist will determine if the recipient is eligible for Medicaid, establish the recipient's dates of eligibility, and ensure that the state's Medicaid computer system is updated.

Once the recipient meets eligibility for the date the service is requested, the provider must contact the area Medicaid office. The area Medicaid office will advise the state Medicaid office to issue a prior authorization number.

The state Medicaid office and the Medicaid fiscal agent cannot issue a prior authorization number until the recipient has been determined eligible for the date of service by DCF.

Prior Authorization Number

Once the recipient has been determined eligible by DCF, the state Medicaid office will advise the fiscal agent to send a letter advising the provider that the procedure was approved or denied.

A letter advising the provider of approval will contain the prior authorization number needed to bill Medicaid.

Note: See Special Billing for Medically Needy Recipients in this chapter for information on billing the service if it was performed on the recipient's first day of eligibility.

Time Frame

The prior authorization process takes 4 to 6 weeks. Medical bills submitted by the recipient to the Department of Children and Families in order to meet his share of cost must be acted upon by his caseworker within 10 days after receipt.

Prior Authorization For Out-of-State Services

Introduction

A Florida Medicaid primary care or specialist physician may refer a Medicaid recipient for out-of-state care to obtain medically necessary services that cannot be provided in Florida. The Florida attending physician must request and obtain prior authorization before the recipient receives out-of-state services.

This is not the same authorization number as the MediPass primary care provider's authorization number. A Florida Medicaid physician may not authorize out-of-state services; he may only request authorization for the services.

If the Florida Medicaid recipient is in Children's Medical Services, the request for out-of-state services must be initiated through Children's Medical Services.

Out-of-state services may not be post authorized.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on out-of-state services.

Physician Prior Authorization Request

The Florida Medicaid primary care or specialist physician must initiate the out-of-state request, unless the recipient is in Children's Medical Services; complete the Medicaid Authorization Request form, PA 01; and provide medical documentation to support the out-of-state request and documentation indicating that the requested service(s) is not available in Florida.

The Medicaid primary care or specialist physician is a Florida licensed physician who diagnosed the illness, disease or infirmity for which the prior authorization is being requested from the Medicaid program. The physician can be the recipient's primary care physician or a specialty physician.

Required Documentation

The physician must attach documentation that justifies the need for the service, such as medical history, lab reports, etc., and must also include:

- Name and address of the out-of-state facility, and
- Name and telephone number of the out-of-state facility's contact person.

The request cannot be processed without the above information.

Where To Submit

The physician must send the request and required documentation to:

Bureau of Medicaid Services
Medicaid Prior Authorization Unit
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

Prior Authorization For Out-of-State Services, continued

Medicaid Prior Authorization Unit Responsibility

The Medicaid medical consultant will review the out-of-state request and approve or deny it. The decision will normally be rendered within ten business days following the receipt of sufficient documentation. The Prior Authorization Unit will notify both the referring and out-of-state providers. If the request is approved, a prior authorization number will be assigned and instructions for filing the claim(s) will be mailed to the provider.

Out-of-State Provider Reimbursement

Florida Medicaid can reimburse the out-of-state provider in one of the following ways:

- The provider's out-of-state Medicaid rate, if they participate in the Medicaid program in their state.
- The average per diem rate paid by Florida Medicaid to in-state Florida general acute care hospitals that is in effect on the date(s) of service. Payment is applied per day and is all-inclusive.
- The average per diem rate paid by Florida Medicaid to in-state Florida teaching or specialty hospitals that is in effect on the date(s) of service. Payment is applied per day and is all-inclusive.
- A mutually agreed upon negotiated rate with the out-of-state provider can be paid by Florida Medicaid, if that is the option of choice. The rate is negotiated as a percentage of the usual and customary charge. Negotiated rates can be made up to but not to exceed 85 percent of the usual and customary charge.

Filing Claims

Once an out-of-state provider has rendered services associated with the approved prior authorization, the out-of-state provider must send the claim(s) and a copy of the authorization approval to the Florida Medicaid fiscal agent for processing and reimbursement.

Providers who are not currently enrolled will be sent enrollment instructions by the fiscal agent once their claims are received. An out-of-state provider must enroll with Florida Medicaid in order to be reimbursed. Upon completion of the enrollment process, appropriate reimbursement will be made.

Note: See Chapter 1 in this handbook for the addresses to send the claim forms.

Authorization for Inpatient Hospital Admissions

Introduction

Medicaid recipient admissions for medical, surgical, and rehabilitative services must be authorized by a peer review organization (PRO). The purpose of authorizing inpatient admissions is to ensure that inpatient services are medically necessary in accordance with 59G-1.010 (166), F.A.C.

Certain types of admission, i.e., emergencies, are exempt from prior authorization by the PRO; other types require no authorization to be admitted to the hospital, but the PRO must authorize the concurrent and continued inpatient stays. These exemptions are listed on the following pages.

Admission for certain recipients is also exempt from the prior authorization by the PRO. The recipient exemptions are listed on the following page.

For recipients who are retroactively Medicaid eligible and already discharged from the hospital, the PRO performs a retrospective prepayment review of their admission and inpatient stay before Medicaid payment can be made.

Treating Provider's Responsibility

The recipient's treating provider is responsible for requesting authorization for inpatient hospitalization admission from the PRO. The hospital may initially request authorization from the PRO instead of the treating provider if there is a mutual understanding between the provider and the hospital that the hospital will assume that responsibility.

If the treating provider is requesting the authorization, it is the treating provider's responsibility to give the PRO the hospital provider's National Provider Identifier that the hospital will use to bill the PRO-approved days to Medicaid. The hospital's zip code plus 4 or taxonomy must be included with the NPI if they were used to register the provider's NPI with Medicaid.

The provider is also responsible to give the PRO the recipient's ten-digit Medicaid identification number.

The hospital's claim will be denied if it is submitted to Medicaid with an NPI (and zip code plus 4 or taxonomy if applicable) or recipient number that is different from the NPI or recipient number that was submitted to the PRO when requesting prior authorization.

Authorization for Inpatient Hospital Admissions, continued

Recipients Exempt from Authorization

Hospital admissions for the following recipients are exempt from prior authorization by the PRO:

- Children and adult recipients who are members of a Medicaid HMO and who have not used their 45 days of inpatient coverage in the Medicaid fiscal year. (HMO enrollees, including recipients under 21 years old, are limited to 45 days of inpatient hospital care under the HMO plan. When recipients under the age of 21 have exhausted their 45-day coverage under the HMO, they become eligible for coverage under fee-for-service. See prior authorization requirements for this age group in the information block labeled "Elective Admissions for Recipients under age 21.")
- Recipients in Provider Service Networks (PSNs).
- Children in the Children Medical Services (CMS) Network. (Children in the CMS Network are also in MediPass. Their inpatient admissions must be authorized by their MediPass primary care providers.)
- Recipients with any type of Medicare coverage; and
- Admissions for Child Health Check-Up recipients under 21 years who have been screened within one year of an inpatient admission for a surgical procedure, and for whom the medically necessary admission was the direct result of the Child Health Check-Up screening performed by a physician.

Types of Admission

Certain types of admissions to the inpatient hospital setting require authorization from the PRO, either prior to admission or once the recipient has been admitted. The types of admission discussed in the following sections are:

- Type of admission "1" (Emergency)
- Type of admission "2" (Urgent)
- Type of admission "3" (Elective)
- Type of admission "4" (Newborn)
- Type of admission "5" (Trauma)

Authorization for Inpatient Hospital Admissions, continued

Emergency or Trauma Admissions

Prior authorization from the PRO is not required to admit a Medicaid recipient of any age when the type of admission is an emergency or trauma.

An authorization number is not required for one day emergency or trauma cases when the recipient is:

- Admitted and discharged the same day, or
- Is admitted one day and discharged the next day.

If the recipient remains in the hospital more than one day, the hospital must request concurrent review from the PRO within 24 hours of the admission and obtain an authorization number to bill the approved days.

Urgent Admission

Prior authorization is not required to admit a Medicaid recipient of any age when the type of admission is urgent. Once the recipient is admitted, the hospital must request an admission review from the PRO within 24 hours of the admission. An authorization number is required for the hospital to bill all approved inpatient days of an urgent admission, whether the stay was one day or more.

Elective Admissions for Children Under 21

Prior authorization from the PRO is not required to admit a Medicaid recipient under the age of 21 when the type of admission is elective, except for a gastric bypass or a hysterectomy. An authorization number is not required for a one-day elective admission when the recipient is:

- Under 21 years of age.*
- Admitted and discharged the same day.
- Admitted one day and discharged the next day.

*An exception occurs if the child is a member of an HMO and has exhausted his 45 days of inpatient coverage in a fiscal year under the HMO. The child's inpatient admission and continued stay must be authorized by the PRO.

If any recipient under 21 remains in the hospital more than one day, the hospital must request a concurrent review from the PRO for days subsequent to the first day. All days approved by the PRO must be billed with an authorization number.

Authorization for Inpatient Hospital Admissions, continued

Admissions for Children Who Have Exhausted Their Medicaid HMO Coverage

Authorization for inpatient admissions and stays is required for children under 21 who have exhausted all 45 days of inpatient coverage in a fiscal year under a health maintenance organization (HMO) while members of such a plan.
The process of obtaining authorization for this group is the same as for all other types of inpatient admissions noted earlier in this chapter.

Inpatient Services Exempt from Authorization

The following services are exempt from PRO authorization:

- Single day inpatient treatment of an emergency admission.
- Same day admission and discharge for a recipient who expires.
- All inpatient days for Medicaid-eligible newborns whose mothers are not Medicaid eligible.

The following services are exempt from PRO authorization, because they are prior authorized by other procedures:

- Inpatient psychiatric and substance abuse services. (See Prior Authorization for Inpatient Psychiatric and Substance Abuse Services in this chapter for the authorization procedures.)
- Emergency inpatient services rendered in out-of-state hospitals to Florida recipients traveling out of state. (See Authorization for Out-of-State Services in this chapter for out-of-state authorization procedures.)
- Evaluation and heart transplantation for adult recipients 21 and older. (See Prior Authorization Requirements in this chapter for authorization procedures.)

Elective Admission for Adults 21 and Over

Elective admissions for adult recipients require prior approval by the PRO before the recipient can be admitted.

Admissions for Delivery Services

Effective February 1, 2008, all hospital admissions for deliveries of newborns must have inpatient authorization. Claims submitted to Medicaid for reimbursement of the delivery event must have a coding combination of at least one of the diagnosis and delivery codes listed below:

- Diagnosis codes 630.0—677, and
- Procedure codes 72.0—74.9, 75.50—75.69.

A prior authorization will be required for the claim to be reimbursed.

Authorization for Inpatient Hospital Admissions, continued

In-State Admissions for Transplant Services

Inpatient admissions of recipients of any age for Medicaid-covered transplant services require authorization from the PRO before services can be rendered.

Exceptions are the following organ transplants that must be prior authorized by the Medicaid medical consultant for reimbursement.

- Organ transplants reimbursed by global payment methodology:
  - ⇒ Adult heart, liver, and lung evaluations and transplants; and
  - ⇒ Pediatric lung evaluations and transplants.
- Out-of-state transplants and evaluations.

Prior authorization for organ transplants reimbursed by global payment methodology must be requested from the Agency for Health Care Administration (AHCA), Bureau of Medicaid Services.

Note: For additional information, see Authorization for Organ Transplant Services in this chapter.

Admissions for Aliens

Inpatient admission for non-qualified, non-citizens who are eligible for Medicaid under the Emergency Medicaid for Aliens category of assistance must be authorized by the PRO, if authorization is required for the type of admission.

Medicaid coverage of inpatient services for non-qualified, non-citizens is limited to emergencies, newborn delivery services, and dialysis services.

Note: See Chapter 3 in the Provider General Handbook for additional information on Emergency Medicaid for Aliens.

Admissions for Recipients with TPL Coverage

Inpatient admissions for recipients with third party liability (TPL) insurance coverage require authorization from the PRO when the hospital already knows the inpatient services will not be covered or paid by the third party payer, if authorization is required for the type of admission.

The process for obtaining authorization is the same as for other types of admissions noted earlier in this chapter.

Authorization for Inpatient Hospital Admissions, continued

Non-Concurrent Newborn Inpatient Stay

The inpatient stay of a newborn who stays in the hospital after his Medicaid eligible mother is discharged is referred to as a non-concurrent newborn stay. The mother's discharge date becomes the newborn's first inpatient day and is exempt from authorization from the PRO. However, authorization is required from Day 2 if the newborn stays longer than one day.

Individuals with Pending Medicaid Eligibility and Medically Needy Recipients

In cases of pending Medicaid eligibility for an individual who is in the hospital, the hospital must notify the PRO as soon as it is known that the individual became Medicaid eligible during the course of the inpatient stay. The hospital must request the PRO to conduct a concurrent review of the stay, beginning with the recipient's first day of Medicaid eligibility while an inpatient.

This procedure also applies to admissions for Medically Needy recipients who meet their share of cost during an inpatient hospital stay.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for a description of the Medically Needy Program. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.

Authorization for Facility Transfers

When a recipient is admitted to one facility, and subsequently needs to be transferred to another facility, the following procedures for facility to facility transfers apply:

- The first hospital to receive the recipient must request authorization from the PRO, if authorization is required for the type of admission. Either the provider or the hospital may obtain the authorization from the PRO. If authorization is necessary, an authorization number is required for billing
- The second hospital receiving the transferred recipient does not need PRO authorization to admit the recipient; but within 24 hours of the admission, must request an admission review from the PRO, and concurrent reviews subsequently, if necessary. An authorization number is required for billing.

Authorization for Inpatient Hospital Admissions, continued

PRO Prior Authorization Process

To request authorization, the treating provider or hospital must fax an admission request to the PRO prior to the admission. The provider may contact the PRO at 866-889-6510 or via the Internet at www.keprosouth.com.

Following the PRO's approval of the hospital's or treating provider's admission request, the PRO issues an authorization number to the hospital receiving the recipient. Should the recipient remain in the hospital longer than the number of days initially approved by the PRO, the hospital must request concurrent review of the subsequent days.

Prior Authorization Number

The PRO issues a ten-digit prior authorization number to the hospital provider for each approved admission and continued stay. Prior authorizations are valid for 120 days.

PRO Denials and Reconsiderations

A hospital provider or corresponding treating provider who is dissatisfied with a PRO denial of an inpatient admission or stay can request a reconsideration of the determination. This must be requested in accordance with the procedures established by the PRO for reconsideration reviews.

If the PRO approves an originally denied admission or stay, the hospital will receive an authorization number to bill the inpatient days to Medicaid for reimbursement.

Retrospective Prepayment Review

Retrospective prepayment review refers to the type of PRO review the hospital must request for individuals who were discharged from the hospital prior to obtaining Medicaid-eligibility confirmation or are recipients with third party liability (TPL) insurance coverage, who were admitted and discharged before the hospital knew if the TPL insurer would cover any part of the inpatient stay.

The PRO performs a retrospective review of the admission and inpatient stay prior to Medicaid payment. This type of review applies to inpatient services for:

- Pending eligibles.
- Medically Needy recipients.
- Recipients with third party insurance coverage when the recipient was admitted and discharged before the hospital had any knowledge of whether the TPL insurer would cover the stay in whole, in part, or not at all.

Authorization for Inpatient Hospital Admissions, continued

Where to Go for Assistance with Authorization Issues

The PRO may be contacted by phone at 866-889-6510 or on its Website at www.keprosouth.com. The PRO Website also has various types of information relevant to the inpatient authorization process.

Information is also available on AHCA's Website at http://ahca.myflorida.com. Click on Medicaid, and then click on Utilization Review.

Prior Authorization for Inpatient Psychiatric and Substance Abuse Services

Non-Emergency Psychiatric and Substance Abuse Admissions

Authorization for non-emergency inpatient psychiatric or substance abuse admission must be requested from First Health 24 hours prior to the admission. The telephone number to call for authorization is 800-770-3084.

Authorization for Inpatient Psychiatric and Substance Abuse Services

Inpatient psychiatric and substance abuse services require authorization before Medicaid payment can be made. Prior authorization must be requested for any admitting diagnosis in the range of ICD-9-CM codes 290-314.0 or 648.30 – 648.44. A physician provider must obtain prior authorization for these services for all Medicaid recipients, except for recipients who are:

- Enrolled in a Health Maintenance Organization (HMO), or
- Dually-eligible for Medicare and Medicaid.

Emergency Psychiatric and Substance Abuse Admissions

Authorization for emergency inpatient psychiatric and substance abuse admissions must be requested from First Health within two (2) hours of admission. The telephone number to call for authorization is 800-770-3084.

Duration of Authorization

Hospital inpatient psychiatric and substance abuse admissions are authorized for a period not to exceed three (3) days. If a hospitalization is anticipated to exceed three (3) days, the provider must contact First Health 24 hours prior to the last approved day and request a continued stay review.

Prior Authorization for Inpatient Psychiatric and Substance Abuse Services, continued

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Prior Authorization Number

First Health issues a ten-digit prior authorization number for each approved hospitalization. There is no prior authorization number required for acute care health practitioners providing psychiatric and substance abuse services. However, certain requirements may apply to these providers in order for the hospital or facility to receive authorizations or continuation of services.

Transfer from Non-Psychiatric Status to Psychiatric and Substance Abuse Status

If a recipient is admitted to the hospital for a non-psychiatric diagnosis and during the same hospitalization is transferred to the psychiatric unit for treatment of psychiatric or substance abuse diagnoses, the recipient must be discharged from the non-psychiatric admission and re-admitted for psychiatric or substance abuse treatment. The psychiatric admission must be prior authorized by First Health.

Two separate admissions are considered in this case. The claims for the first admission are considered medical in nature and follow the guidelines of all other medical inpatient authorizations. The second portion of the hospital stay is considered a psychiatric admission authorized by First Health.

Note: See Authorization for Inpatient Hospital Admissions in this chapter for more information on the prior authorization process for medical admissions.

Alcohol or Drug Detoxification Services

Inpatient alcohol or drug detoxification services are considered medical services and not psychiatric services. Inpatient admissions for such services are authorized by the peer review organization (PRO) contracted for medical inpatient services. First Health is not responsible for such services. An authorization must be obtained from the PRO for these inpatient admissions.

Note: See Authorization for Inpatient Hospital Admissions in this chapter for more information on the prior authorization process for medical admissions.

Prior Authorization for Inpatient Psychiatric and Substance Abuse Services, continued

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Psychiatric Patient in Medical Bed in Facility with CON for Inpatient Psychiatric Services

When a recipient with a psychiatric admitting diagnosis of 290-314.9 or 648.30-648.44 is placed in a medical unit within a hospital that has a Certificate of Need (CON) for inpatient psychiatric services, both the psychiatric PRO and the medical PRO will each have to authorize a portion of the inpatient stay. The authorization procedure is as follows:

- The hospital must request the medical PRO review the case from admission to the point of medical stability or up to the point of transfer to the care of a psychiatrist. This portion of the stay is billed with a medical PRO authorization number. Only the days involving medical PRO authorization are reported on this claim.
- At the point of transfer from medical care to psychiatric treatment by a psychiatrist, the hospital must discharge the recipient from medical care, readmit for psychiatric care, and request authorization from the psychiatric PRO for the psychiatric stay. This portion of the stay is billed with the psychiatric PRO authorization number. Only the days involving the psychiatric PRO authorization are reported on this claim.

When all psychiatric beds within a hospital are occupied and there are no psychiatric beds available in other vicinity hospitals, and the only resort for the hospital is to place the recipient in a medical bed, the hospital must inform the psychiatric PRO when requesting authorization that all efforts to place the recipient in a psychiatric bed have been exhausted.

PRO Denials and Reconsiderations

A hospital provider who is dissatisfied with a psychiatric PRO denial can request a reconsideration of the determination. This must be requested in accordance with the procedures established by the PRO for reconsideration reviews.

If the psychiatric PRO approves an originally denied admission or stay, the hospital will receive an authorization number to bill the inpatient days to Medicaid for reimbursement.

Where to Go for Assistance with Authorization Issues

The psychiatric PRO may be contacted by phone at 800-770-3084. Additional information on First Health may be found at http://florida.fhsc.com. Information is also available on AHCA's Website at http://ahca.myflorida.com. Click on Medicaid, and then click on Utilization Review.

Authorization for Organ Transplants

Introduction

The peer review organization (PRO) is responsible for the authorization of all transplant services. Exceptions are:

- Organ transplants reimbursed by global payment methodology:
  - ⇒ Adult heart, liver, and lung evaluations and transplants; and
  - ⇒ Pediatric lung evaluations and transplants.
- Out-of-state transplants and evaluations.

Prior authorization for organ transplants reimbursed by global payment methodology and for out-of-state transplants must be requested from the Agency for Health Care Administration (AHCA), Bureau of Medicaid Services. The transplant physician requests the authorization from Medicaid and obtains an authorization number that is shared with the hospital provider for billing purposes. Authorizations for organ transplants are valid for 365 days.

Consultations for Globally Reimbursed Transplants

Consultations by a transplant specialist at an AHCA-designated transplant center must be completed prior to the submission of the prior authorization request for the comprehensive heart, liver, or lung transplant evaluation. A copy of the consultation must be attached to the prior authorization request with documentation stating the patient qualifies for a heart, liver, or lung transplant evaluation.

Adult Heart, Liver, and Lung and Pediatric Lung Transplant Evaluation

The comprehensive evaluation must be performed at an AHCA-designated heart, liver, or lung transplant facility. The comprehensive evaluation is completed by the AHCA-designated facility's transplant team for determination of candidacy for a transplant surgical procedure.

The comprehensive transplant evaluation may be performed in either the inpatient hospital setting, if the recipient requires hospitalization, or outpatient hospital setting. Inpatient evaluations are not permitted solely for the convenience of the physician or the recipient.

Reimbursement for the comprehensive transplant evaluation is not available until all final results of the evaluation are made available to the Medicaid medical consultant and the recipient is either approved and listed with the United Network of Organ Sharing (UNOS) or is determined a non-candidate.

Authorization for Organ Transplants, continued

Adult Heart, Liver, and Lung, and Pediatric Lung Transplant Surgery

If approved, accepted, and listed with UNOS, the AHCA-designated center must notify Medicaid headquarters. A copy of the following documents must be forwarded to the transplant coordinator for global reimbursement:

- A complete copy of the comprehensive transplant evaluation;
- UNOS listing date and status; and
- Completed prior authorization requesting authorization for transplant surgical services.

Where To Submit Prior Authorization Requests

Submit all prior authorization requests for organ and bone marrow transplants to:

Agency for Health Care Administration
ATTN: Transplant Coordinator
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

No facsimile prior authorizations are accepted.

Authorization for Out-of-State Transplant Services

The Bureau of Medicaid Services authorizes out-of-state evaluations and transplants prior to an out-of-state referral. Out-of-state transplant referrals are approved only when the recipient has a special medical condition requiring the more sophisticated treatment offered by a particular out-of-state transplant center, or when there is the lack of a facility in Florida to perform the transplant procedure.

The transplant physician at the AHCA-designated transplant center in Florida must initiate the authorization request for the out-of-state transplant referral. The request is sent to the above address.

An authorization number is issued for an approved out-of-state transplant request. The out-of-state hospital utilizes the authorization number to bill Medicaid for the transplant service(s) rendered.

Note: See Chapter 3 in the Florida Medicaid Hospital Coverage and Limitations Handbook for the method of reimbursement for out-of-state services. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.160, F.A.C.

Special Billing For Medically Needy Recipients

Introduction

A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid's income or resource limits. On a month-by-month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the month or for part of the month. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called a "share of cost."

Split Billing and CF-ES Form 2902

If a recipient incurred medical expenses from multiple providers on the date he met his share of cost (first day of eligibility), any medical expenses from a single provider that were used in full to meet the share of cost are **not** eligible for Medicaid reimbursement. Any expenses from a single provider that were not used in full to meet the share of cost **are** eligible for reimbursement. This process, known as "split billing," is actually split-day billing—no individual claims are split and no claims from a single source are split. This process occurs infrequently.

If not all of the recipient's medical expenses incurred on the first day of eligibility are eligible for Medicaid reimbursement, the MEVS split bill indicator will be "Y." The public assistance specialist will mail a pink copy of the Medically Needy Billing Authorization, CF-ES Form 2902, June 2003, to the providers whose expenses are eligible for reimbursement. Providers must submit the CF-ES Form 2902 with their claims so the Medicaid fiscal agent will know that the claims are eligible for reimbursement.

If the MEVS split bill indicator is "N," then all the recipient's expenses incurred on the first day of eligibility are eligible for reimbursement and a CF-ES Form 2902 is not required.

Note: The Medically Needy Billing Authorization, CF-ES Form 2902, June 2003, is incorporated by reference in 59G-4.001, F.A.C.

Receiving an CF-ES Form 2902

When a provider receives a pink copy of a CF-ES Form 2902, the provider must check the bottom right-hand corner of the form, under the caption "Period of Eligibility," and make sure that the dates of service on the claim fall within the recipient's period of eligibility.

If the service was performed on the first day of eligibility indicated on the CF-ES Form 2902, the form must be submitted with the claim. If the service dates are after the first day of eligibility, the form does not need to be submitted with the claim.

Special Billing For Medically Needy Recipients, continued

Instructions for Submitting a CF-ES Form 2902

If one or more services were provided on the first day of eligibility, follow the instructions below.

- Attach the pink copy of the CF-ES Form 2902 to the claim being sent to the Medicaid fiscal agent if appropriate as described above.
- The provider should make a photocopy of the pink copy for the office record.
- If a claim is for a Medically Needy recipient and was originally filed with a pink CF-ES Form 2902 and must be resubmitted or adjusted, a photocopy of the CF-ES 2902 must accompany the claim resubmission or adjustment.
- When submitting a photocopy of CF-ES Form 2902, the provider must enter the internal control number (ICN) of the previous claim on the photocopy of the CF-ES Form 2902, in the box labeled “For Provider Use Only” in the upper right corner of the CF-ES Form 2902. The photocopy will be rejected if the provider does not enter the previous claim’s ICN on the form.

Note: See Chapter 2 in this handbook for information on the ICN and the remittance voucher.

Illustration 3-3 CF-ES Form 2902

FLORIDA DEPARTMENT OF
CHILDREN & FAMILIES

MEDICALLY NEEDY BILLING AUTHORIZATION

FOR PROVIDER USE ONLY
Enter Transaction Control Number

DATE ____________________

DISTRICT________ COUNTY________ UNIT________

CASE NAME____________________

Dear Provider

The individual listed below has been determined eligible for Medicaid benefits under the Medically Needy Program for the period indicated. The PINK ORIGINAL of this form is the only proof of eligibility. This form, NOT A COPY, must be attached to all claims submitted to Medicaid for payment of Medicaid covered services provided to the eligible individual on the first day of eligibility as shown below. ANY CLAIM FOR MEDICAID COVERED SERVICES RENDERED ON THE FIRST DAY OF ELIGIBILITY THAT IS SUBMITTED WITHOUT THIS FORM ATTACHED WILL BE DENIED.

You can bill Medicaid for Medicaid compensable services provided during the period of eligibility for the eligible individual identified on this form. PAYMENTS CAN ONLY BE MADE FOR MEDICAID SERVICES TO MEDICAID PROVIDERS.

You may call the Medicaid fiscal agent at the following toll free telephone number, if you have any questions about the billing procedures:

1-800-289-7799

If you have any questions about this form or the eligibility of the individual on this form, you may contact the Department of Children and Families office at the telephone number listed below.

AUTHORIZED SIGNATURE ______________________ TELEPHONE # ____________
Economic Self-Sufficiency Specialist

Eligible Individual	Medicaid #	Period of Eligibility First Day through Last Day mm/dd/yy mm/dd/yy
	#	through

CF-ES 2902, Jun 2003 (Obsoletes previous editions which may not be used)
(Stock Number: 3CF-00146)

Incorporated by reference in 59G-4.001, F.A.C.

Special Billing For Medically Needy Recipients, continued

Explaining The Form

The preceding illustration corresponds to the following explanations.

ITEM	TITLE	WHAT ITEM MEANS
Upper Left	**Provider's Address**	The provider's name and address. If the provider receives a form addressed to another provider, he must not use it. It must be returned to the sender.
Upper Right	**For Provider Use Only (Enter Transaction Control Number)**	If the first claim for services was denied, use a copy of the original pink form and enter the first claim's transaction control number in this item. This item does not need to be completed on original pink forms.
Bottom Left	**Eligible Individual**	The name of the recipient eligible for the Medically Needy Program.
Bottom Center	**Medicaid Identification Number (Medicaid ID #)**	The 10-digit Medicaid identification number for the recipient listed in the "Eligible Individual."
Bottom Right	**Period of Eligibility**	The date Medicaid coverage begins and ends for the recipient. Medicaid coverage is through the "Last Day" shown in this item. The form only needs to be attached to a claim for services given to the recipient on the "First Day" shown on the form.

Out-Of-State Claims

Covered Services

Florida Medicaid will reimburse out-of-state services under the following circumstances:

- An emergency arising from an accident or illness that occurred while the recipient is out of state;
- The recipient's health will be endangered if the care and services are postponed until returning to Florida;
- The child is a non Title IV-E Florida foster or adoption subsidy child living out of state and is covered under the Florida Medicaid program; or
- Florida Medicaid determines, on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in the other state and prior authorizes the out-of-state services.

Note: Providers located in Georgia or Alabama who regularly provide services to Medicaid recipients may enroll as in-state providers. See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on providers located in Georgia or Alabama.

Claims for Emergency Treatment

Documentation justifying the emergency must be submitted with the claim to the Florida Medicaid fiscal agent for payment. If the out-of-state provider is not already enrolled when a claim is submitted, the fiscal agent will send the provider enrollment materials.

Claims for Foster Care and Adoption Subsidy Children

An out-of-state provider submits the claim according to the instructions in this handbook for filing the claim.

Note: See Chapter 1 in this handbook for information on filing a claim.

Consent For Sterilization Form

Introduction

Federal regulations require both male and female recipients to give written consent prior to sterilization procedures being performed. To meet this requirement, the provider must submit with the claim a Consent For Sterilization Form, HHS-687 (11/06) that the recipient has signed.

A copy of the Consent For Sterilization Form and instructions on how to complete it are on the following pages.

Note: English and Spanish versions of the Consent For Sterilization Form can be obtained from the federal Department of Health and Human Services' website at http://www.hhs.gov/forms. The forms can also be obtained from the Medicaid fiscal agent by calling 800-289-and selecting Option 7 or downloading the forms from the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Forms. The forms are incorporated by reference in 59G-4.001.

Note: See Surgery in Chapter 2 of the service-specific Coverage and Limitations Handbook for additional information on sterilizations.

Consent Time Limits

The waiting period between obtaining the recipient's written consent and the sterilization procedure must be at least 30 days, but no more than 180 days.

Premature Delivery

In the event of premature delivery, the recipient's written consent must have been completed and signed at least:

- 30 days prior to the expected date of delivery, and
- 72 hours prior to the sterilization.

Abdominal Surgery

In the event of emergency abdominal surgery, the recipient's written consent must have been completed and signed at least 72 hours prior to the sterilization procedure.

Non-Medicaid Covered Sterilization

A Consent for Sterilization form is not required when a non-covered sterilization procedure is performed in conjunction with a Medicaid-covered child delivery (normal or Cesarean section). The non-covered sterilization must not lengthen the inpatient stay for normal and Cesarean section deliveries.

When billing for a delivery when the mother received a non-covered sterilization, all code references to a sterilization procedure must be deleted from the claim so it can be processed without a sterilization consent form.

***Consent For Sterilization Form**, continued*

Form Completion Requirements	All blanks on the Consent For Sterilization Form must be completed and signed and dated on the same date by the recipient, the interpreter if one is used, and the person who obtained the consent. The date of the sterilization procedure in the physician's statement on the Consent For Sterilization form must be identical to the date of service on the claim form. The physician who performed the sterilization must sign and date the Consent For Sterilization form on or after the date that the sterilization procedure was performed.
Form Processing Requirements	The Consent For Sterilization Form must be submitted with every claim submitted for Medicaid reimbursement for sterilization procedures.
Correcting Items on the Form	Any item on the form may be corrected **except** for the signatures of the patient, the person who obtained consent, the interpreter, and the date(s) signed.
Consent For Sterilization Form Instructions and Samples	A copy of the Consent For Sterilization form with step-by-step instructions and a sample-completed form are on the following pages.

Illustration 3-4 Consent For Sterilization Form (Front Side)

Form Approved: OMB No. 0937-0166
Expiration date: 11/30/2009

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from ______________ (*doctor or clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: ______________ (*Month Day Year*)

I, ______________, hereby consent of my own free will to be sterilized by ______________ (*doctor*) by a method called ______________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

______________ *Signature* Date: ______________ *Month Day Year*

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

______________ *Interpreter's Signature* ______________ *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before ______________ (*name of individual*) signed the consent form, I explained to him/her the nature of sterilization operation ______________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

______________ *Signature of person obtaining consent* ______________ *Date*

______________ *Facility*

______________ *Address*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ______________ (*name of individual*) on ______________ (*date of sterilization*). I explained to him/her the nature of the sterilization operation ______________ (*specify type of operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: ______________
- ☐ Emergency abdominal surgery *(describe circumstances)*:

____

____

______________ *Physician's Signature* ______________ *Date*

HHS-687 (11/2006)

FSC Graphics (301) 443-1090 EF

Incorporated by reference in 59G-4.001, F.A.C.

Illustration 3-4.1 Consent For Sterilization Form (Back Side)

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

HHS-687 (11/2006)

Incorporated by Reference in 59G-4.001, F.A.C.

Illustration 3-5 Spanish Consent For Sterilization Form (Front Side)

Forma Aprobada: OMB No. 0937-0166
Fecha de expiración: 11/30/2009

CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información de

____
(médico o clínica)

sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como _______________.
Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el: _______________
(día, mes, año)

Yo, _______________________________, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada / o por _______________________________
(médico)

por el método llamado _______________________________.
Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

_______________________________ fecha: _______________
(firma) *(día, mes, año)*

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo: *(Definición de raza y origen étnico)*

Origen étnico:
☐ Hispano o latino
☐ No hispano o latino

Raza (marque según aplique):
☐ Indígena americano o indígena de Alaska
☐ Asiático
☐ Negro o afroamericano
☐ Natural de Hawaii u otras islas del Pacífico
☐ Blanco

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de consentimiento en idioma _______________________ y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

_______________________________ _______________
(firma del intérprete) *(fecha)*

■ DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO ■

Antes de que _______________________________
(nombre de persona)

firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación

_______________________________, para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento.

He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

_______________________________ _______________
(firma de la persona que obtiene el consentimiento) *(fecha)*

____
(lugar)

____
(dirección)

■ DECLARACIÓN DEL MÉDICO ■

Previamente a realizar la operación para la esterilización a

____
(nombre de persona esterilizada/o)

en _______________________. Le expliqué a él/ella los detalles de
(fecha de esterilización)

esta operación para la esterilización

_______________________________, del hecho de que
(especifique tipo de operación)

es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente.

Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.

(**Instrucciones para uso alternativo de párrafos finales**: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique.)

(1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

☐ Parto prematuro
Fecha prevista de parto: _______________
☐ Cirugía abdominal de urgencia *(Describa las circunstancias)*:

____

____

_______________________________ _______________
(firma del médico) *(fecha)*

HHS-687-1 (11/2006)

PSC Graphics (301) 443-1090 EF

Incorporated by reference in 59G-4.001, F.A.C.

Illustration 3-5.1 Spanish Consent For Sterilization Form (Back Side)

DECLARACIÓN SOBRE LEY DE REDUCCIÓN DE TRÁMITES

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.

Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

HHS-687-1 (11/2006)

Incorporated by reference in 59G-4.001, F.A.C.

Consent For Sterilization Form, continued

Completing The Consent For Sterilization Form

Use the following instructions to complete the Consent For Sterilization Form.

CONSENT TO STERILIZATION	
	Enter the name of the physician or the name of the clinic from which the recipient received sterilization information (no abbreviations).
	Enter the type of operation (no abbreviations).
	Enter the recipient's date of birth (MM/DD/YY).
	Enter the recipient's name. The recipient's name should be the same in each section of the form.
	Enter the name of the physician performing the surgery.
	Enter the type of operation (no abbreviations), the same as in #2 above.
	The recipient to be sterilized signs here.
	The recipient dates signature here.
	Check one box appropriate for recipient. This item is requested but NOT required.

INTERPRETER'S STATEMENT	
	Enter the name of the language the information was translated to, including sign language.
	Interpreter signs name here.
	Interpreter dates signature here.

STATEMENT OF PERSON OBTAINING CONSENT	
	Enter the recipient's name.
	Enter the type of operation again (no abbreviations). This must be the same as the type of operation that is listed under Consent to Sterilization.
	The person obtaining consent signs here.
	The person obtaining consent dates his signature here. This must be the same date as the date that is listed under Consent to Sterilization.
	The person obtaining consent enters the **complete** name of the facility or office where that person is employed. If there is no facility name, enter "Office of Dr. _______."
	The person obtaining consent enters the complete physical address of facility above. Address must be complete, including state and zip code.

Consent For Sterilization Form, continued

PHYSICIAN'S STATEMENT	
	Enter the recipient's name.
	Enter the date of sterilization operation.
	Enter type of operation again (no abbreviation). This must be the same as the type of operation that is listed under Consent to Sterilization.
	Cross out the paragraph that does not apply to the recipient, either (1) or (2). If (2) applies, check the appropriate boxes. If the Premature Delivery box is checked, write in the expected date of delivery in the following box. If emergency abdominal surgery is checked, describe circumstances here.
	Physician who performed sterilization signs here.
	Physician dates his signature here. (A date prior to surgery is invalid.)

Illustration 3-6 Sample Completed Consent For Sterilization Form

Form Approved: OMB No. 0937-0166
Expiration date: 11/30/2009

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from John James, M.D. (*doctor or clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ligation of Fallopian Tubes. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: 01/05/60 (*Month Day Year*)

I, Anne Smith, hereby consent of my own free will to be sterilized by John James, M.D. (*doctor*) by a method called ligation of Fallopian Tubes. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Anne Smith (*Signature*) *Date:* 07/31/08 (*Month Day Year*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ____________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

____________ *Interpreter's Signature* ____________ *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before Anne Smith (*name of individual*) signed the consent form, I explained to him/her the nature of sterilization operation ligation of Fallopian Tubes, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Mary Acton, R.N. (*Signature of person obtaining consent*) 7/31/08 (*Date*)

ACME Family Planning Center (*Facility*)

101 Bay Street, Anywhere, FL 32300 (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon Anne Smith (*name of individual*) on 9/16/08 (*date of sterilization*).

I explained to him/her the nature of the sterilization operation ligation of Fallopian Tubes (*specify type of operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

~~(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):~~

~~☐ Premature delivery~~
~~Individual's expected date of delivery: ____________~~

~~☐ Emergency abdominal surgery *(describe circumstances)*:~~

John Jones, M.D. (*Physician's Signature*) 9/16/08 (*Date*)

HHS-687 (11/2006)

PSC Graphics (301) 443-1090 EF

Hysterectomy Acknowledgment Form

Introduction

Federal regulations require that a recipient or her representative be informed verbally and in writing prior to a hysterectomy that the operation will make her permanently incapable of reproducing. Federal regulations further require that the recipient or her representative sign a written acknowledgment of receipt of this information.

If a recipient was not eligible for Medicaid on the date the hysterectomy was performed but becomes retroactively eligible, the provider must have either obtained a Hysterectomy Acknowledgment Form, HAF 07/1999, or a consent form that includes the same information as the Hysterectomy Acknowledgment Form in order to be reimbursed by Medicaid. If the provider did not obtain a Hysterectomy Acknowledgment Form or a consent form that contains the same information, Medicaid cannot reimburse for the service.

A copy of the Hysterectomy Acknowledgment Form and instructions on how to complete it are on the following pages.

Note: Hysterectomy Acknowledgment Forms can be obtained from the Medicaid fiscal agent by calling 800-289-and selecting Option 7. The form may also be downloaded from the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Forms. The Hysterectomy Acknowledgment Form is incorporated by reference in 59G-4.001, F.A.C.

Form Completion Requirements

All blanks on the Hysterectomy Acknowledgment Form must be completed.

Form Processing Requirements

The acknowledgment form must be submitted with every physician and hospital claim submitted for Medicaid reimbursement, unless the recipient meets the requirements of the Exception to Hysterectomy Acknowledgment Requirement Form.

Note: See Exception To Hysterectomy Acknowledgment Requirement Form for information on when a hysterectomy may be performed without the recipient's prior acknowledgment.

Illustration 3-7 Hysterectomy Acknowledgment Form

STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

______________________________, __________________, understand that the Florida
(PRINT PHYSICIAN'S NAME) (PROVIDER NO.)
Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

____
(ENTER DX AND EXPLAIN IF NECESSARY)

____

____

____

______________________________ __________________
PHYSICIAN'S SIGNATURE DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

____
(PRINT: RECIPIENT'S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

______________________________ __________________
PATIENT'S SIGNATURE OR MARK DATE

Patient's mark must be witnessed by her representative.

______________________________ __________________
INTERPRETER'S SIGNATURE, WHEN NECESSARY DATE

DISTRIBUTION OF COPIES:
ORIGINAL - Retain in patient's medical record at physician's office.
1 COPY - To patient.
Other copies as required - See note below.

NOTE: A copy of this form shall be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.

HAF 07/1999

Incorporated by reference in 59G-4.001, F.A.C.

Incorporated by reference in 59G-5.020, F.A.C.

Hysterectomy Acknowledgment Form, continued

Completing The Form

Complete the Hysterectomy Acknowledgment Form using the following instructions.

TITLE	ACTION
Physician's Name	Enter the name of the physician performing the hysterectomy procedure.
Provider Number	Enter the physician's nine-digit Medicaid provider number or National Provider Identifier (NPI). We recommend entering the same provider number that is on the claim form so that the person who opens the claim does not separate the form from the claim.
Enter Dx and Explain	Enter the diagnosis that requires the hysterectomy procedure. Provide further explanation, if necessary.
Physician's Signature	Original physician's signature. Signature stamps or delegated signatures are not allowed.
Date	Enter the date the physician signs the form.
Recipient's Name and Medicaid ID Number	Enter the recipient's name (first then last name) as it appears on the gold, plastic Medicaid identification card or other proof of eligibility. Enter the *verified* 10-digit Medicaid ID number, not the eight-digit card control number from the front of the card.
Patient's Signature	Original patient's signature or mark. If the patient makes a mark only, obtain the signature of her representative as a witness.
Date	Enter the date the recipient signed the form.
Interpreter's Signature	If the recipient does not speak or understand English, obtain the signature of the person interpreting the statements on the form to the recipient.
Date	Enter the date the interpreter signed the form.

Illustration 3-8 Completed Hysterectomy Acknowledgment Form

STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

John Jones, M.D. (PRINT PHYSICIAN'S NAME), 012345789 (PROVIDER NO.), understand that the Florida Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

617.0 Endometriosis of uterus

(ENTER DX AND EXPLAIN IF NECESSARY)

John Jones, M.D. — PHYSICIAN'S SIGNATURE
07/15/04 — DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

Anne P. Smith 123456780

(PRINT: RECIPIENT'S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

Anne P. Smith — PATIENT'S SIGNATURE OR MARK
07/15/04 — DATE

Patient's mark must be witnessed by her representative.

INTERPRETER'S SIGNATURE, WHEN NECESSARY
DATE

DISTRIBUTION OF COPIES:

ORIGINAL - Retain in patient's medical record at physician's office.
1 COPY - To patient.
Other copies as required - See note below.

NOTE: A copy of this form shall be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.

HAF 07/1999

Exception To Hysterectomy Acknowledgment Requirement Form

Introduction

In specific circumstances, federal regulations allow Medicaid payment for hysterectomy procedures without the recipient's prior acknowledgment. A physician's written certification statement is required for the specific circumstances.

A copy of the Exception to Hysterectomy Acknowledgment Requirement Form, ETA 07/2001, and instructions for completion are on the following pages.

Note: Exception to Hysterectomy Acknowledgment Requirement Forms can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 7. The form may also be downloaded from the Medicaid fiscal agent's Web Portal at http://floridamedicaid.acs-inc.com. Click on Public Information for Providers, then on Provider Support, and then on Forms. The form is incorporated by reference in 59G-4.001, F.A.C.

Specific Circumstances Requiring Form

An Exception to Hysterectomy Acknowledgment Form is required if the recipient:

- Was sterile before the hysterectomy was performed; or
- Required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior completion of the Hysterectomy Acknowledgment Form was not possible.

Hysterectomy and Retroactive Medicaid Eligibility

Medicaid recipients may be retroactively eligible for Medicaid for up to three months prior to their month of application for Medicaid benefits. A physician who performs a hysterectomy on a recipient who has not been determined eligible for Medicaid, but who is subsequently determined eligible for the month in which the hysterectomy was performed, must certify in writing that:

- The recipient was informed before the operation that the hysterectomy would make her permanently incapable of reproducing; or
- The recipient meets one of the conditions listed above.

In addition to the physician's written certification of informed consent, the appropriate hysterectomy form must be submitted with the claim.

Illustration 3-9. Exception to Hysterectomy Acknowledgment Requirement Form

STATE OF FLORIDA
EXCEPTION TO HYSTERECTOMY ACKNOWLEDGEMENT REQUIREMENT
State of Florida Physicians Certification Statement for Exception to Hysterectomy Acknowledgement Requirement

SECTION I

I ____________________________, ____________________ certify that
(PRINT PHYSICIAN NAME) (PROVIDER NUMBER)
the condition(s) marked below existed at the time a hysterectomy was performed for ________________________, ________________________.
(PRINT RECIPIENT'S NAME) (MEDICAID I.D. NUMBER)

_______ A. The recipient was already sterile at the time of the hysterectomy.

Specify cause of sterility:

_______ Postmenopausal

_______ Congenital disorder: Specify ____________________

_______ Previously surgically sterilized: Specify method ____________________

_______ B. The recipient requires an emergency hysterectomy because of a life threatening emergency situation. (The emergency situation must render the recipient incapable of understanding or responding to the information pertaining to the acknowledgement agreement because of the emergency nature of her admission). Please describe the nature of the emergency below.

1 2 3 4 5 6 7 8

SECTION II

Physician Statement of Certification

For the above reason(s), I am requesting an exception to the hysterectomy acknowledgement requirement for the hysterectomy services indicated on the attached claim for (CMS-1500 or UB 04).

____________________ (Physician Signature)

____________________ Fiscal Agent Screening Supervisor

____________________ (Date)

9 10

ETA 07/2008

Incorporated by reference in 59G-4.001, F.A.C.

Exception To Hysterectomy Acknowledgment Requirement Form*, continued*

Completing The Form

Complete the Exception to Hysterectomy Acknowledgment Requirement Form using the following instructions.

TITLE	ACTION
Physician's Name	Enter the certifying physician's name.
Provider Number	Enter the certifying physician's nine-digit Medicaid provider number or National Provider Identifier (NPI). We recommend entering the same provider number that is on the claim form so that the person who opens the claim does not separate the form from the claim.
Recipient's Name	Enter the recipient's name as it appears on the gold, plastic Medicaid identification card or other proof of eligibility.
Medicaid ID Number	Enter the recipient's verified Medicaid identification number, not the eight-digit card control number from the front of the card.
A. Was Patient Sterile?	Check if patient was already sterile at the time of the procedure, and check and write in the specific cause of the sterility.
B. Life Threatening Emergency	Check if the recipient required a hysterectomy because of a life threatening emergency situation.
Physician's Signature	Obtain the signature of the certifying physician.
Date	Enter the date the certifying physician signed the form.
Fiscal Agent Screening Supervisor	Leave blank.

Illustration 3-10 Completed Exception to Hysterectomy Acknowledgment Requirement Form

STATE OF FLORIDA
EXCEPTION TO HYSTERECTOMY ACKNOWLEDGEMENT REQUIREMENT
State of Florida Physicians Certification Statement for Exception to Hysterectomy Acknowledgement Requirement

SECTION I

I John Jones, M.D. (PRINT PHYSICIAN NAME), 123456789 (PROVIDER NUMBER) certify that the condition(s) marked below existed at the time a hysterectomy was performed for Anne P. Smith (PRINT RECIPIENT'S NAME), 0123456789 (MEDICAID I.D. NUMBER).

X A. The recipient was already sterile at the time of the hysterectomy.

Specify cause of sterility:

______ Postmenopausal

______ Congenital disorder: Specify ____________________

X Previously surgically sterilized: Specify method Ligation of Fallopian Tubes

______ B. The recipient requires an emergency hysterectomy because of a life threatening emergency situation. (The emergency situation must render the recipient incapable of understanding or responding to the information pertaining to the acknowledgement agreement because of the emergency nature of her admission). Please describe the nature of the emergency below.

1 2 3 4 5 6 7 8

SECTION II

Physician Statement of Certification

For the above reason(s), I am requesting an exception to the hysterectomy acknowledgement requirement for the hysterectomy services indicated on the attached claim for (CMS-1500 or UB 04).

John Jones, M.D.
(Physician Signature)

8/15/08
(Date)

____
Fiscal Agent Screening Supervisor

9 10

ETA 07/2008

Abortion Certification Form

Introduction

Federal regulations allow payment for abortions only for specific reasons and require the physician to certify the reason for the abortion.

Abortions may be reimbursed by Medicaid for one of the following reasons:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- The pregnancy is the result of an act of rape.
- The pregnancy is the result of an act of incest.

The physician must record the reason for the abortion in his or her medical records for the recipient.

Form Completion Requirements

A copy of the Abortion Certification Form, AHCA-Med Serv Form 011, August 2001, and instructions for completion are on the following pages.

All spaces on the form must be completed according to the instructions for the form.

Note: Abortion Certification Forms can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 7. The form may also be downloaded from the Medicaid fiscal agent's Web Portal at http://mymedicaid-Florida.com. Click on Public Information for Providers, then on Provider Support, and then on Medicaid Forms. The form is incorporated by reference in 59G-4.001, F.A.C.

Form Processing Requirements

The Abortion Certification Form must be submitted with every claim for Medicaid reimbursement for an abortion and abortion-related procedures.

Illustration 3-11 Abortion Certification Form

State of Florida Abortion Certification Form

SECTION I

1. Recipient's Name:________________________________

2. Address:________________________________

3. Medicaid Identification Number:________________________________

SECTION II

4. On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:
   - ☐ The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
   - ☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
   - ☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the patient's medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ________________________________
Physician's Name

6. ________________________________
Physician's Signature

7. ________________________________
Physician's Medicaid Provider Number

8. ________________________________
Date of Signature

AHCA-Med Serv Form 011, August 2001

Incorporated by reference in 59G-4.001, F.A.C.

Abortion Certification Form, continued

Completing The Form

Complete the Abortion Certification Form using the following instructions.

FORM ITEM	TITLE	ACTION
		Section I
1	Recipient's Name	Enter the recipient's name as it appears on the gold, plastic Medicaid identification card or other proof of eligibility.
2	Address	Enter the street address of the recipient. Include street and number, apartment number (if applicable), city, state and zip code.
3	Medicaid Identification Number	Enter the recipient's verified 10-digit Medicaid identification number, not the eight-digit card control number from the front of the card.
		Section II
4	Reason	Identify the reason for which the abortion procedure was performed by placing a check mark on the appropriate line. Only one reason can be checked.
5	Physician's Name	Print or type the name of the physician who performed the abortion procedure.
6	Physician's Signature	Signature of the physician who performed the abortion procedure. (Same name as #7)
7	Medicaid Provider Number	Enter the nine-digit Medicaid provider number of the physician who signed the form or National Provider Identifier (NPI). We recommend entering the same provider number that is on the claim form so that the person who opens the claim does not separate the form from the claim.
8	Date	Physician enters date of signature here.

Florida's Healthy Start Prenatal Risk Screening Instrument

Introduction

The purpose of the Healthy Start Prenatal Risk Screening Instrument, DH 3134, 2/01, is to identify pregnant Medicaid recipients who are at risk for poor birth outcomes and may need interventions to prevent or reduce complications.

Note: See Chapter 2 of the Physician, Advanced Registered Nurse Practitioner and Physician Assistant Coverage and Limitations Handbooks for information about the Healthy Start Prenatal Risk Screening.

Where to Obtain Forms

Forms can be obtained from local county health departments. Instructions for completion are on the back of the form. The form is incorporated by reference in 59G-4.001, F.A.C.

Form Processing Requirements

The provider files his copy of the Healthy Start Prenatal Risk Screening form in his medical records for the recipient. Do not submit the Healthy Start form with the claim.

A copy of the Healthy Start Prenatal Risk Screening Instrument is on the following page.

Illustration 3-12 Healthy Start Prenatal Risk Screening Instrument

Black ink only **Florida's Healthy Start Prenatal Risk Screening Instrument**

SECTION 1: COMPLETED BY PATIENT

Your name: First | Last | M.I. | Your County: | Today's Date (month, day, year): — Census Tract (local use)

Your street address (apartment complex name/number): | Your city or town: | Your state: | Your zip code:

Your mailing address (if different from street address): | Your city or town: | Your state: | Your zip code:

To be completed by Health Professional

Your home phone: | Your work phone or other: | Your birthdate (month, day, year): | Your age: | Your social security number: | Your race: black ❑ white ❑ other ❑ — A<18 (1) A>39 (1) RB (2)

Are you married? yes ❑ no ❑ | Have you graduated from high school or received a GED? yes ❑ no ❑ | When you were born, did you weigh 5½ pounds or less? yes ❑ no ❑ don't know ❑ — MN T (1) PHN T

Your weight before pregnancy: lbs. | Your Height: ft. in. | Is this your first pregnancy? If no, give date your last pregnancy ended (include live birth, stillbirth, miscarriage, abortion). yes ❑ no ❑ Date: (month, year)__________

Is your prenatal care covered by: Health Insurance/HMO ❑ __________ Medicaid ❑ Other Health Insurance (Military, Indian Health, etc.)❑ __________ No Coverage ❑ — EN T (1) W<110 (1)

If you would like to be screened for Healthy Start, please write your initials under yes. If not, write your initials under no. Please sign your name at the bottom of this section.

Yes No (initials)

___ ___ I am interested in being screened for Florida's Healthy Start. If yes, complete the following screening questions **by checking** the appropriate boxes.

	Yes	No	N/A		(check marks)	
1.	❑	❑		1.	Do you have any problems which prevent you from keeping your health care or social services appointments?	1Y (1)
2.	❑	❑		2.	Have you moved more than 3 times in the last 12 months?	2Y T (1)
3.	❑	❑		3.	Do you feel unsafe where you live?	3Y (1)
4.	❑	❑		4.	Do you or any member of your household go to bed hungry?	4Y (1)
5.	❑	❑		5.	In the last 2 months, have you used any form of tobacco?	5Y (1)
6.	❑	❑		6.	In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)?	6Y T (1)
7.	❑	❑		7.	In the last year, has anyone hit you or tried to hurt you?	7Y T
8.	a❑b❑c❑			8.	How do you rate your current stress level? (a) low, (b) medium, (c) high	8C T
9.	a❑b❑c❑ d❑			9.	If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no change	9C T (1)
10.	❑	❑		10.	Have you considered adoption for this pregnancy?	10Y T
11.	❑	❑		11.	Do you now, or have you ever had, problems with depression?	11Y T
12.	❑	❑		12.	Do you have a history of receiving mental health counseling?	12Y T
13.	❑	❑	❑	13.	Is your partner unemployed?	13Y T

Yes No (initials) **If you would like to participate in the program if invited, please write your initials under yes. If not, initial no.**

___ ___ **If I am invited**, I accept the invitation to participate in Florida's Healthy Start. The best time to contact me is: __________

Please initial yes or no for consent to release information on this form and any information from the initial contact for the purposes below.

Yes No (initials)

___ ___ The information on this form is confidential, and will not be released without my written consent. I hereby authorize the release of any information on this form and any information from the initial contact to Healthy Start care coordination providers, Healthy Start Coalitions, and where available, Healthy Families Florida for the following purposes: for care coordination services, to pay for claims for services, to evaluate service delivery, or to screen for program eligibility. This includes any medical, psychiatric, psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information that is included on this form or provided by me during the initial contact.

⇨ ____________________ __________

Signature of patient or guardian **Date (mm/dd/yy)**

SECTION 2: BY PROVIDER

Yes	No	N/A		
14❑	❑	❑	14. Did patient's last pregnancy result in a miscarriage, stillbirth, a baby less than 5½ pounds, a baby born more than 3 weeks early, or a baby that stayed in the hospital after the patient went home?	14Y (1)
15❑	❑		15. Does patient have any illness that requires continuing medical care? Specify illness: __________	15Y (1)

Name and Title of Health Care Provider: | Provider's ID: | Provider's Phone Number:

Provider's Mailing Address: | City or Town: | Zip Code: | County Where Practice is Located:

❑ CHD Provider ❑ DOH Contracted Provider ❑ Private Provider | LMP (mo,day,year) | EDD (mo,day,year) | Trimester of pregnancy at first prenatal visit: — =2T (1) 2 or 3T T

Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.)
Term _____ Preterm _____ Abortion _____ Living _____ Low Birth Weight (less than 5½ pounds)_____

Healthy Start Screening Score _____ **CHECK ONE**
- ❑ **Invited to participate in Healthy Start based on score.**
- ❑ **Invited to participate in Healthy Start based on factors other than score. Specify :** __________
- ❑ **Not referred for Healthy Start.**

I have explained the Healthy Start program, and if screened, the screening score.

____________________ __________

Provider's/Interviewer's Signature and Title **Date (mm/dd/yy)**

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

DH 3134, 2/01 stock number 5744-100-3134-7 Distribution of copies: WHITE & YELLOW - County Health Department in county where screening occurred PINK - Retained in patient's record GREEN - Patient's Copy

Incorporated by reference in 59G-4.001, F.A.C.

APPENDIX A

INTERNAL CONTROL NUMBER (ICN) REGION CODES

APPENDIX A
INTERNAL CONTROL NUMBER (ICN) REGION CODES

Region	Code Description
00	ALL CLAIM REGIONS
10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	INTERNET CLAIMS WITH NO ATTACHMENTS
23	INTERNET CLAIMS WITH ATTACHMENTS
25	POINT OF SERVICE CLAIMS
26	POINT OF SERVICE CLAIMS WITH ATTACHMENTS
40	CLAIMS CONVERTED FROM OLD MMIS
41	ENC CLM CONVERTED FROM OLD MMIS
45	FFS CLM ADJ CONVERTED FROM OLD MMIS
46	ENC CLM ADJ CONVERTED FROM OLD MMIS
47	ENC CLM VOID CONVERTED FROM OLD MMIS
48	FFS CLM VOID CONVERTED FROM OLD MMIS
49	RECIPIENT LINKING CLAIMS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS - CHECK RELATED
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - PROVIDER RETRO RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
57	ADJUSTMENTS - VOID CHECK RELATED
58	ADJUSTMENTS - HISTORY ONLY CHECK RELATED
59	POS REVERSAL ADJUSTMENT
60	CHOW ADJUSTMENTS - HISTORY ONLY VOID
61	CHOW ADJUSTMENTS - HISTORY ONLY
62	CHOW ADJUSTMENTS - PROVIDER RATES
64	ADJUSTMENTS - ENCOUNTER
65	ADJUSTMENTS - ENCOUNTER VOID
66	MASS ADJUSTMENTS - ENCOUNTER
67	MASS ADJUSTMENTS - ENCOUNTER VOID
69	POS REVERSAL/ INTERNET/ 837 – ENCOUNTER
70	ENCOUNTERS
80	CLAIMS REPROCESSED BY EDS SYSTEMS ENGINEERS
90	SPECIAL PROJECTS
91	BATCHES REQUIRING MANUAL REVIEW
97	SINGLE RESUBMISSION
98	MASS RESUBMISSION

Charlie Crist
Governor

Holly Benson
Secretary

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