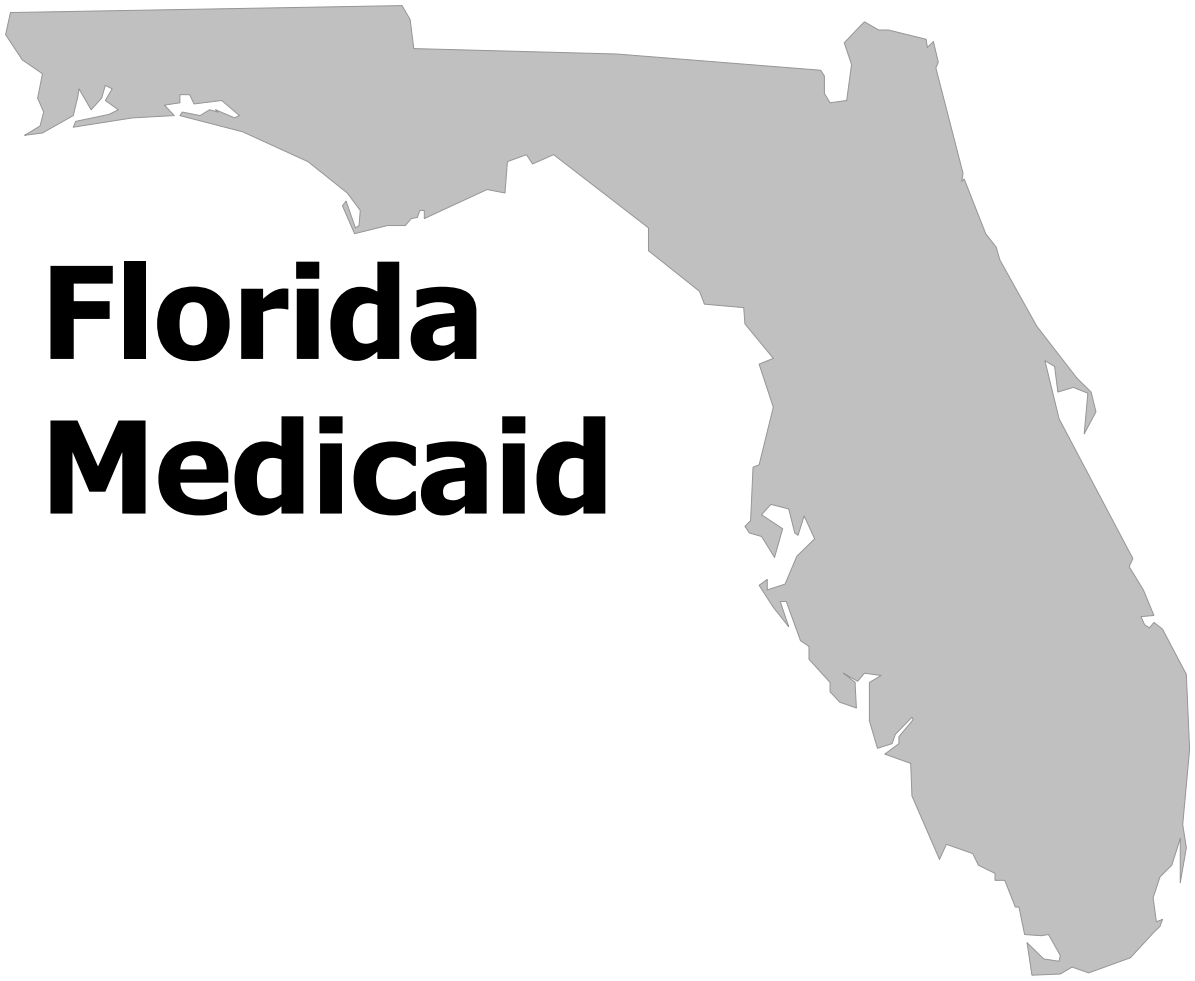

Florida Medicaid

Provider Reimbursement Handbook, UB-04

Agency for Health Care Administration

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

FLORIDA MEDICAID

Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

December 1, 2008

Dear Medicaid Provider:

Please find the enclosed Florida Medicaid Provider Reimbursement Handbook, UB-04, 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 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 Web Portal 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 A 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
UB-04

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
May07 New Handbook	May 2007
Jul08 Revised Handbook	July 2008

FLORIDA MEDICAID PROVIDER REIMBURSEMENT HANDBOOK
UB-04

Table of Contents

Chapter 3 – Additional Filing Requirements, continued

Appendices

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, who is eligible to receive them, and the fee schedules.
- 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.
- Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide 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 provides 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 are 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 provides 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 short and regular way of displaying difficult, 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 help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important 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 list of topics 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 be:

1. 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.
2. 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 previous 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 at the bottom 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 identified 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 identified 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 identified 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 identified by a vertical line to the left and right of the paragraph.

Paragraph with new material.

CHAPTER 1
COMPLETING THE UB-04 CLAIM FORM

Overview

Introduction

This chapter describes how to complete and submit the UB-04 claim form for payment from the Florida Medicaid Program through the Medicaid fiscal agent. The UB-04 claim form is incorporated by reference in 59G-4.003, F.A.C.

UB-04 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.

In This Chapter

This chapter contains:

Providers Who Bill on the UB-04 Claim Form

Provider Responsibility

Florida Medicaid has applied 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 800-289-7799 and select Option 3 or call 866-586-0961.

Providers Who Are Required to Bill on the UB-04 Claim Form

The following providers, when billing on a paper claim form must bill on a UB-04 claim form to receive reimbursement from Medicaid:

- Freestanding Dialysis Centers
- Hospitals
- Hospital-Based Skilled Nursing Facilities
- Hospices
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Nursing Facilities
- State Mental Hospitals
- Rural Swing Bed Providers
- Statewide Inpatient Psychiatric Program (SIPP) Waiver providers

Providers Who Bill on the UB-04 Claim Form, continued

Provider Types Who Bill Crossover Claims on the UB-04 Claim Form

The following providers who bill Medicaid services on the CMS-1500 claim form must complete and submit UB-04 claim forms to receive reimbursement from Medicaid when billing Medicare-Medicaid crossover paper claims:

- Federally Qualified Health Centers
- Independent Therapists
- Rural Health Clinics

Note: The CMS-1500 (08/05) claim form is incorporated by reference in 59G-4.001, F.A.C. It is available from the Medicaid fiscal agent by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Electronic Claim Submission

The policies in this handbook for completing a paper UB-04 claim form are applicable to all claim submissions.

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

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 forms by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Basic Rules

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

- Make sure the UB-04 is the right form to use for the claim.
- Use one original claim form for each recipient.
- Enter all information in black type or 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 (whiteout) on the claim form. Use correction tape to make corrections.
- Complete the form using the service-specific Florida Medicaid Coverage and Limitations Handbooks as a reference.

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 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 a claim form, please answer the following questions:

- Was the recipient Medicaid eligible on the date of service?
- Has the recipient's eligibility been verified?
- Was the peer review organization (PRO), MediPass, health maintenance organization (HMO), prepaid mental health plan (PMHP), or physician service network (PSN) authorization obtained and entered on the claim form, if applicable?
- Was the service or item provided covered by Medicaid?
- Was prior authorization obtained for inpatient hospitalization from the PRO, if applicable?
- Does the amount of patient responsibility for long term care (skilled nursing facilities and ICF/DDs) and hospice services match the most current written documentation from the Department of Children and Families?
- Has a claim been filed, and a response received, for all other insurance held by the recipient?
- Was the procedure within the service limitations?
- Does the claim require any medical documentation or attachments?

If all of the above information is not available, review the instructions in this handbook.

If the response to all of the above questions is "yes," fill out the claim form following the step-by-step instructions for each item on the form.

How to Complete the UB-04 Claim Form

Introduction

This section contains an illustration of the UB-04 claim form, step-by-step instructions, and sample completed forms.

CHAPTER 1
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- Rural Health Clinics

Note: The CMS-1500 (08/05) claim form is incorporated by reference in 59G-4.001, F.A.C. It is available from the Medicaid fiscal agent by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Electronic Claim Submission

The policies in this handbook for completing a paper UB-04 claim form are applicable to all claim submissions.

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

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.

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Time Limit for Submission of a Claim Form, continued

Claim Adjustment Requests

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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.

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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 forms by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Basic Rules

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

- Make sure the UB-04 is the right form to use for the claim.
- Use one original claim form for each recipient.
- Enter all information in black type or 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 (whiteout) on the claim form. Use correction tape to make corrections.
- Complete the form using the service-specific Florida Medicaid Coverage and Limitations Handbooks as a reference.

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 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 a claim form, please answer the following questions:

- Was the recipient Medicaid eligible on the date of service?
- Has the recipient's eligibility been verified?
- Was the peer review organization (PRO), MediPass, health maintenance organization (HMO), prepaid mental health plan (PMHP), or physician service network (PSN) authorization obtained and entered on the claim form, if applicable?
- Was the service or item provided covered by Medicaid?
- Was prior authorization obtained for inpatient hospitalization from the PRO, if applicable?
- Does the amount of patient responsibility for long term care (skilled nursing facilities and ICF/DDs) and hospice services match the most current written documentation from the Department of Children and Families?
- Has a claim been filed, and a response received, for all other insurance held by the recipient?
- Was the procedure within the service limitations?
- Does the claim require any medical documentation or attachments?

If all of the above information is not available, review the instructions in this handbook.

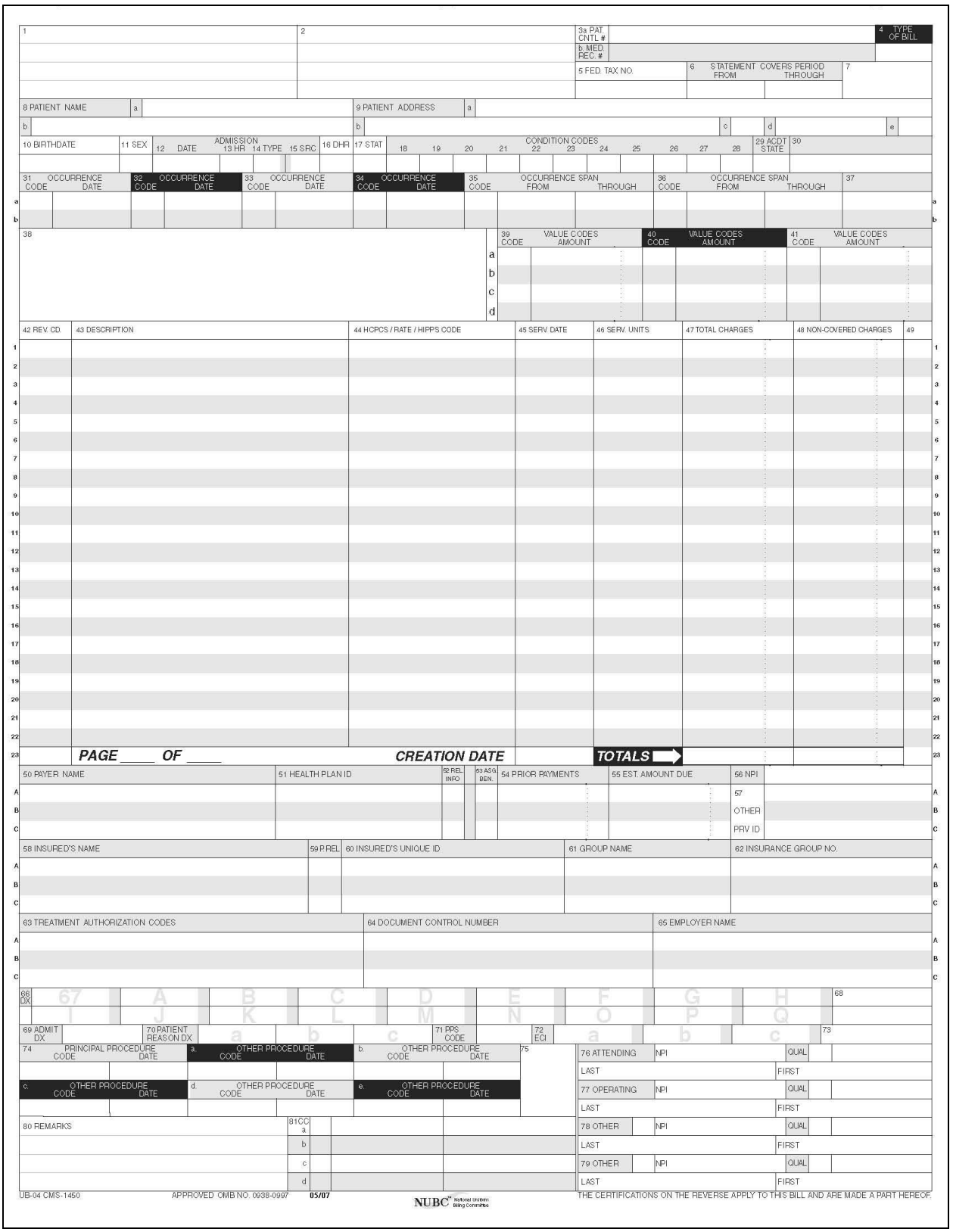
If the response to all of the above questions is "yes," fill out the claim form following the step-by-step instructions for each item on the form.

How to Complete the UB-04 Claim Form

Introduction

This section contains an illustration of the UB-04 claim form, step-by-step instructions, and sample completed forms.

Illustration 1-1. The UB-04 Claim Form



Incorporated by reference in rule 59G-4.003, F.A.C.

Illustration 1-2. Reverse Side of the Claim Form

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Illustration 1-2. Reverse Side of the Claim Form

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

How to Complete the UB-04 Claim Form, continued

Refer to the Form Locator Numbers on the sample claim form on page 1-5.

FORM LOCATOR	TITLE	ACTION
1	**Provider Name, Address, Telephone Number, Fax Number, and Country Code**	Line 1: Provider Name Line 2: Street Address or Post Office Box Line 3: City, State, and Zip Code plus 4 Line 4: Telephone; Fax; Country Code (if other than USA)
2	**Pay-To Name, Address, and ID**	Report only when pay-to name and address is different than the Billing Provider in Form Locator 1.
3a	**Patient Control Number**	Enter patient's unique (alphanumeric) number assigned by the provider. Any letter or number combination up to 20 digits is acceptable. This number will be included on the payment check or remittance.
3b	**Medical Record Number**	This is an optional item. Enter the number assigned to the patient's medical or health record by the provider. Entries in this field will not be keyed or returned to the providers on remittances.
4	**Type of Bill**	Enter the appropriate four-digit code for the type of bill from the coding table below. **Inpatient Type of Bill Codes:** 0110 Inpatient Non-Payment (Zero Claim) 0111 Inpatient Admit through Discharge Date 0112 Interim (First Claim) 0113 Interim (Continuing Claim) 0114 Interim (Last Claim) 0117 Inpatient Replacement of Prior Claim (Adjustment) 0118 Inpatient Void (Cancel of Prior Claim) 0121 Inpatient Medicare B Only **Outpatient Type of Bill Codes**: 0130 Outpatient Non-Payment (Zero Claim) 0131 Outpatient Claim 0137 Outpatient Replacement of Prior Claim (Adjustment) 0138 Outpatient Void (Cancel of Prior Claim) 0141 Outpatient Non-Patient Diagnostic Laboratory Claim

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
4	**Type of Bill (Continued)**	**Critical Access Hospitals:** 0851 Special Facility—Critical Access Hospital Original Claims 0857 Special Facility—Critical Access Hospital Replacement of Prior Claim (Adjustment) 0858 Critical Access Hospital Voids **Freestanding Dialysis Center Type of Bill Codes**: 0721 Freestanding Dialysis Center Original Claims 0727 Freestanding Dialysis Center Replacement of Prior Claim (Adjustment) 0728 Freestanding Dialysis Center Voids **Hospice Type of Bill Codes**: 0813 Hospice Original Claims 0817 Hospice Replacement of Prior Claim (Adjustment) 0818 Hospice Voids **Long Term Care (Skilled Nursing and ICF/DDs) Type of Bill Codes:** 0251 Skilled Nursing Facility (SNF) Level I Original Claims 0257 Skilled Nursing Facility (SNF) Level I Replacement of Prior Claim (Adjustment) 0258 Skilled Nursing Facility (SNF) Level I Voids 0261 Skilled Nursing Facility (SNF) Level II Original Claims 0267 Skilled Nursing Facility (SNF) Level II Replacement of Prior Claim (Adjustment) 0268 Skilled Nursing Facility (SNF) Level II Voids 0651 Intermediate Care Facility (ICF) Level I Original Claims 0657 Intermediate Care Facility (ICF) Level I Replacement of Prior Claim (Adjustment) 0658 Intermediate Care Facility (ICF) Level I Voids 0661 Intermediate Care Facility (ICF) Level II Original Claims 0667 Intermediate Care Facility (ICF) Level II Replacement of Prior Claim (Adjustment) 0668 Intermediate Care Facility (ICF) Level II Voids
5	**Federal Tax Number**	Upper Line: Optional federal tax sub-ID number. Lower Line: Enter as NN-NNNNNNN

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
6	**Statement Covers Period – From Through**	**Inpatient**: Enter the beginning and ending service dates for this bill in month, day, and year format: MMDDYY. For admission and discharge on the same day, both the "From" and "Through" dates are the same. Inpatient medical or psychiatric claims for dates of service overlapping fiscal years (June into July) do not require split billing. Entire hospitalizations may be submitted on one single claim. Split billing is required only for interim bills and for the circumstances described immediately below under **Inpatient Psychiatric Services**. There is, however, one exception where the provider will want to split the bill. For those infrequent cases where recipients have exhausted their benefits, a claim that spans across the state fiscal year must be split billed in order for the Florida Medicaid fiscal system to recognize the beginning of a new inpatient 45-day cap limit period and pay the days after June 30. The system judges the number of days left in a recipient's cap based on the "FROM" date on the UB-04 claim form (Form Locator 6). **Inpatient Psychiatric Services**: Enter the beginning and ending service dates of the period included by this bill in MMDDYY format. Split bill when preparing inpatient claims with a primary diagnosis of 290-314.9 or 648.30-648.44 (psychiatric and substance abuse), if one or more of the following conditions exist: • Inpatient stay exceeds 30 days. • There is a discharge from a non-psychiatric admission and a readmission for psychiatric treatment or vice versa within the same hospital stay. **Outpatient**: Enter the date of service in MMDDYY format. Only the services received in a single day can be billed on an outpatient claim, with the exception of outpatient Medicare crossover claims. The from and through dates are the same. **Freestanding Dialysis Center:** Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient's Medicaid eligibility began. For services received on a single day, the from and through dates must be the same. (Continued)

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
6	**Statement Covers Period – From Through** (Continued)	**Hospice:** Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient's Medicaid eligibility began. For services received on a single day, the from and through dates must be the same. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter the beginning and ending service dates for the month being billed in month, day, year format: MMDDYY.
7	**Unlabeled**	No entry required.
8a	**Patient ID**	Report only if number is different from the insured's ID in Form Locator 60.
8b	**Patient Name**	Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medicaid identification card or other Medicaid proof of eligibility
9	**Patient Address**	Subfield a: Street Address or Post Office Box Subfield b: City Subfield c: State Subfield d: Zip Code Subfield e: Country Code (no entry required)
10	**Patient Birthdate**	Enter the patient's date of birth in the MMDDYYYY format. Example: 04212007 for April 21, 2007.
11	**Patient Sex**	Enter the letter "M" if the patient is male, "F" if the patient is female, or "U" if unknown.
12	**Admission Date**	**Inpatient**: Enter the patient's date of admission in the MMDDYY format. Example: 042107 for April 21, 2007. **Outpatient**: Enter the date of service. **Freestanding Dialysis Centers**: No entry required. **Hospice**: Enter the patient's date of admission in MMDDYY format. This date must be the same as the effective date of hospice election or change of election. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter the patient's date of admission to the facility or to a new Level of Care in MMDDYY format.

How to Complete the UB-04 Claim Form, continued

<table>
<tr><th>FORM LOCATOR</th><th>TITLE</th><th>ACTION</th></tr>
<tr><td>13</td><td>Admission Hour</td><td><u>Inpatient</u>: Not required, but desirable. Enter the code for the hour of admission converted to 24 hour time as shown below:
<table>
<tr><th><u>CODE</u></th><th><u>TIME AM</u></th><th><u>CODE</u></th><th><u>TIME PM</u></th></tr>
<tr><td>00</td><td>12:00-12:59 (Midnight)</td><td>12</td><td>12:00-12:59 (Noon)</td></tr>
<tr><td>01</td><td>01:00-01:59</td><td>13</td><td>01:00-01:59</td></tr>
<tr><td>02</td><td>02:00-02:59</td><td>14</td><td>02:00-02:59</td></tr>
<tr><td>03</td><td>03:00-03:59</td><td>15</td><td>03:00-03:59</td></tr>
<tr><td>04</td><td>04:00-04:59</td><td>16</td><td>04:00-04:59</td></tr>
<tr><td>05</td><td>05:00-05:59</td><td>17</td><td>05:00-05:59</td></tr>
<tr><td>06</td><td>06:00-06:59</td><td>18</td><td>06:00-06:59</td></tr>
<tr><td>07</td><td>07:00-07:59</td><td>19</td><td>07:00-07:59</td></tr>
<tr><td>08</td><td>08:00-08:59</td><td>20</td><td>08:00-08:59</td></tr>
<tr><td>09</td><td>09:00-09:59</td><td>21</td><td>09:00-09:59</td></tr>
<tr><td>10</td><td>10:00-10:59</td><td>22</td><td>10:00-10;59</td></tr>
<tr><td>11</td><td>11:00-11:59</td><td>23</td><td>11:00-11:59</td></tr>
</table>
<u>Outpatient</u>: No entry required, but desirable.
<u>Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)</u>: No entry required.</td></tr>
</table>

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
14	**Type of Admission or Visit**	**Inpatient**: Enter the code indicating the priority of this admission: 1. **Emergency:** The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient is admitted through the emergency room. 2. **Urgent:** The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. 3. **Elective:** The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4. **Newborn:** A baby born within this facility. Use of this code necessitates the use of special Source of Admission codes. See Form Locator 15. 5. **Trauma Center:** Visit to a trauma center or hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involves a trauma activation. 9. Information not available. **Outpatient**: Enter code "1" for emergencies; code "2" for urgent cases; or code "5" (Trauma Center) if the patient was seen in a trauma center or hospital. Otherwise, no entry is required. MediPass authorization is not required if the type of admission is "1" or "5." **Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
15	**Source of Referral for Admission or Visit**	**Inpatient, Hospice, and Freestanding Dialysis Centers**: Enter the code indicating the source of the referral for this admission or visit. Newborn coding must be used when the Type of Admission Code in Form Locator 14 is "4." See next page for newborn codes. **Admission Source Codes**: (Excluding Newborn) **1 – Physician Referral:** The patient was admitted to this facility upon the recommendation of his personal physician. **2 – Clinic Referral:** The patient was admitted to this facility upon recommendation of this facility's clinic physician. **3 – HMO Referral:** The patient was admitted to this facility upon the recommendation of an HMO physician. **4 – Transfer from a Hospital:** The patient was admitted to this facility as a transfer from an acute care facility where he was an inpatient. **5 – Transfer from a Skilled Nursing Facility:** The patient was admitted to this facility as a transfer from a skilled nursing facility where he was a resident. **6 – Transfer from Another Health Care Facility:** The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes and long-term care facilities and skilled nursing patients who are at a non-skilled level of care. **7 – Emergency Room:** The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. **8 – Court or Law Enforcement:** The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative. **9 – Information Not Available:** The means by which the patient was admitted to this facility is not known. **A – Transfer from a Critical Access Hospital**: The patient was admitted to this facility as a transfer from a critical access hospital where he was an inpatient.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
15 (Continued)	**Source of Referral for Admission or Visit**	**Source Codes for Newborns**: **1 - Normal Delivery:** A baby delivered without complications. **2 - Premature Delivery:** A baby delivered with time or weight factors qualifying it for premature status. **3 - Sick Baby:** A baby delivered with medical complications, other than those relating to premature status. **4 - Extramural Birth:** A newborn born in a non-sterile environment. **Outpatient**: No entry required. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.
16	**Discharge Hour**	**Inpatient**: Enter the hour of discharge from the hospital, converted to 24-hour time as shown in the coding table for Form Locator 13. **Outpatient**: No entry required, but desirable. **Freestanding Dialysis Centers**: No entry required. **Hospice**: No entry required. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
17	**Patient Discharge Status**	**Inpatient, Outpatient and Hospice**: Enter the code indicating patient status as of the discharge date or last date billed in the case of interim billing as reported in Form Locator 6–Statement Covers Period. **Patient Status Codes**: 01 Discharged to home or self-care (routine discharge). 02 Discharged or transferred to another short-term general hospital for inpatient care. 03 Discharged or transferred to skilled nursing facility (SNF). 04 Discharged or transferred to an intermediate care facility (ICF). 05 Discharged or transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List. (Discontinued on 9/30/07) Discharged or transferred to a Designated Cancer Center or Children's Hospital (Effective 10/1/07) 06 Discharged or transferred to home under care of organized home health service organization. 07 Left against medical advice or discontinued care. 09 Admitted as an inpatient to this hospital. 20 Expired. 30 Still a patient. (This code is typically used on interim bills and long term care facility claims.) 40 Expired at home. 41 Expired in a medical facility such as a hospital, SNF, ICF, or free-standing hospice. 42 Expired – Place of death unknown. 43 Discharged or transferred to a Federal health care facility.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
17 (Continued)	**Patient Discharge Status**	50 Hospice – home. 51 Hospice – medical facility. 61 Discharged or transferred within this institution to hospital-based, Medicare-approved swing bed. (Hospital swing bed providers must use their swing bed provider number and the UB-04 claim form to bill swing bed services to Medicaid.) 62 Discharged or transferred to inpatient rehabilitation facility, including rehabilitation in distinct part units of a hospital. 63 Discharged or transferred to a Medicare Certified Long Term Care Hospital (LTCH). 64 Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare. 65 Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital. 66 Discharged or transferred to a Critical Access Hospital (CAH). 70 Discharged or transferred to another Type of Health Care Institution not Defined Elsewhere in Code List (Effective 10/1/07, previously code 05). **Freestanding Dialysis Centers**: No entry required. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs):** Enter one of the following codes indicating patient status as of the discharge date**.** 20 – Death 03 – Discharge or transfer to Skilled Nursing Facility 01 – Home 09 – Hospital 30 – Still a patient

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
18-28	**Condition Codes**	**Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1. **Insurance Codes**: 01 Military Service Related. Medical condition incurred during military service. 02 Condition Is Employment Related. Patient alleges that medical condition is due to environment or events resulting from employment. 03 Patient Covered by Insurance Not Reflected Here. Indicates that the recipient or the recipient's representative has stated that coverage may exist beyond that reflected on this claim. 04 Zero Payment – Information Only Bill. Identifies a claim a provider has to submit to Medicaid but for which the provider expects $0.00 (zero) payment. 05 Lien Has Been Filed. 06 End Stage Renal Disease Patient in First 18 Months of Entitlement Covered by Employer Group Health Insurance. 07 Treatment of a Non-Terminal Condition for Hospice Patient. Code indicates the recipient is a hospice enrollee, but the provider is not treating recipient's terminal condition and is, therefore, requesting regular Medicaid reimbursement. Code 07 also indicates the recipient's exemption from inpatient and outpatient hospital copayment requirement. 08 Recipient Would Not Provide Information Concerning Other Insurance Coverage. 10 Patient or Spouse Is Employed but No Employer Group Health Plan Exists for Either Party that Would Cover the Patient.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
18-28 (Continued)	**Condition Codes**	**Accommodation Codes**: 36 General Care Patient in a Special Unit or General Care Beds Temporarily Unavailable 37 Ward Accommodation at Patient Request 38 Semi-Private Room Not Available 39 Private Room Medically Necessary 40 Same Day Transfer: Patient transferred to another facility before midnight on the day of admission 44 Inpatient Admission Changed to Outpatient. For use on outpatient claims only, when a physician ordered inpatient services, but upon internal utilization review, the hospital determined that the services did not meet its inpatient criteria. **Skilled Nursing Facility (SNF) Codes**: 55 SNF Bed Not Available. Code indicates the recipient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available. 56 Medical Appropriateness. Code indicates the recipient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period. 57 SNF Readmission. Code indicates the recipient was previously receiving Medicaid covered SNF care within 30 days of this readmission. **Renal Dialysis Setting Codes:** 71 Full Care in Unit **Special Program Codes**: A1 Child Health Check-Up (formerly EPSDT). Enter Condition Code A1 for recipients under 21 years of age for whom surgery was performed if: • The surgery resulted from the recipient having a Child Health Check-Up screening no longer than one year prior to the date of surgery, and • The screening resulted in the recipient's referral to the physician for treatment of the condition for which the surgery was performed.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
18-28 (Continued)	**Condition Codes**	**Special Program Codes,** continued A4 Family Planning. Enter Condition Code A4 if services included on this claim were provided for family planning purposes. This code is not applicable to hysterectomy or abortion services. If Condition Code A4 is entered on an outpatient claim, it also indicates that a copayment cannot be charged to the recipient accessing the outpatient hospital emergency room, outpatient department, or clinic for family planning services. AA Abortion Performed Due to Rape AB Abortion Performed Due to Incest AD Abortion Performed Due to a Life Endangering Physical Condition Caused by, Arising from, or Exacerbated by the Pregnancy Itself. AI Sterilization. (This code cannot be used for hysterectomies.) **PRO Approval Indicator Series**: C1 Approved as Billed. The services provided for this billing period have been reviewed by the PRO UR, as appropriate, and are fully approved. C3 Partial Approval. The services provided for this billing period have been reviewed by the PRO UR, as appropriate, and some days have been denied. If Code C3 is entered in Form Locators 18-28, you must also enter M0 and the first and last dates of the approved days in Form Locators 35-36. See instructions for Form Locators 35-36. C4 Admission Denied. Enter this code to indicate that the patient's need for inpatient services was reviewed and the PRO UR found that none of the stay was medically necessary.
29	**Accident State**	When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred, i.e., FL, GA, etc.
30	**Unlabeled**	No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
31-34 a—b	**Occurrence Code and Date**	**Inpatient and Outpatient**: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36). After all these fields are exhausted, use Form Locator 81 Code-Code field with qualifier A2. 01 Auto Accident: Code indicating the date of an auto accident. 02 No Fault Insurance Involved Including Auto Accident or Other 03 Accident—Tort Liability 04 Accident—Employment Related 05 Accident No Medical or Liability Coverage 06 Crime Victim 10 Pregnant Woman–No copayment. Use this code on an inpatient or outpatient claim. Code 10 signifies that a copayment cannot be charged to a pregnant or post-partum woman up to two months, who is accessing hospital services, even if the services she needs are non-emergency in nature. 11 Onset of Symptoms or Illness 24 Date Insurance Denied 25 Date Benefits Terminated by Primary Payer 26 Date SNF Bed Available **Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
31-34 a—b (Continued)	**Occurrence Code and Date**	**Newborn Billing**: If the mother is eligible for Medicaid and the infant's length of stay is within the mother's admission and discharge dates, include all charges for the mother and newborn on the same claim. Do not bill separately. Bill in the mother's name and Medicaid ID number. This inpatient stay is referred to as a concurrent newborn stay. • If the mother is not eligible for Medicaid, bill in the newborn's name and Medicaid ID number. • If the Medicaid-eligible newborn was transferred from another hospital, bill in the newborn's name and Medicaid ID number. • If the birth of the newborn was extramural, bill in the newborn's name and Medicaid ID number. • When the mother is eligible for both Medicare Part A and Medicaid during a concurrent stay, bill the claim in the newborn's name and Medicaid ID number. • When the mother is eligible for Medicaid and has third party insurance (TPL) covering the delivery but the newborn is not covered by the TPL insurance, bill in the newborn's name and Medicaid ID number. 42 If the mother **is eligible** for Medicaid, but the newborn's length of stay is longer than the mother's, that is it exceeds the mother's discharge date, enter Occurrence Code 42 followed by the mother's discharge date in this form locator. Bill in the newborn's name and Medicaid ID number. This situation is referred to as a non-concurrent newborn stay. A1 Birth Date - Insured A. The birth date of the individual in whose name the insurance is carried. A2 Effective Date - Insured A Policy. A code indicating the first date insurance is in force. A4 Medically Needy - First Day of Eligibility. Enter this code and the date of the first day of eligibility for a Medically Needy recipient if you have received a pink CF Form 2902 from the local Department of Children and Families. This form must be kept on file in the recipient's hospital record. B1 Birth Date - Insured B. The birth date of the individual in whose name the insurance is carried. B2 Effective Date - Insured B Policy. A code indicating the first date insurance is in force. C1 Birth Date - Insured C. The birth date of the individual in whose name the insurance is carried. C2 Effective Date - Insured C Policy. A code indicating the first date insurance is in force.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
35-36 a—b	**Occurrence Span Code and Dates**	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code "M0" and the first and last days that were approved when not all of the stay was approved.
37	**Unlabeled**	No entry required.
38	**Responsible Party Name and Address**	No entry required.
39-41 a-b-c-d	**Value Codes and Amounts**	**Inpatient and Outpatient**: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable. If all of the Value Code fields are filled, then use Form Locator 81 Code-Code field with qualifier A4. 06 Medicare Part A or B Blood Deductible. Total cash blood deductible, if appropriate. Enter the Part A or Part B blood deductible amount. 07 Medicare Cash Deductible. Medicare cash deductible to be used only if 06 is used and there is a cash deductible. 37 Pints of Blood Furnished. Total number of pints of whole blood or units of packed red cells furnished to the patient. 38 Blood Deductible Pints. The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. 39 Pints of Blood Replaced. The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. 80 Covered Days. The number of days covered by the primary payer as qualified by the payer. 81 Non-Covered Days. Days of care not covered by the primary payer. 82 Co-insurance Days. The inpatient Medicare days occurring after the 60th day and before the 91st day. 83 Lifetime Reserve Days. Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness. **Hospice:** Enter the value code and amount if applicable. 31 Patient Responsibility. If the hospice patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
39-41 a-b-c-d (continued)	**Value Codes and Amounts**	**Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs):** Enter the value code and amount. **31 Patient Responsibility**. If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as one day. The Department of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim. For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period. **80 Covered Days**. The number of days covered by the primary payer as qualified by the payer.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
42	**Revenue Code**	Enter the appropriate four-digit revenue codes itemizing accommodations, services, and items furnished to the patient in your facility. The last revenue code that all provider types billing on the UB-04 must enter on the last page of the claim is revenue code "0001" in Line 23 of Form Locator 42 with the claim total charge amount in Form Locator 47. **Inpatient**: Select from Appendix A in the Florida Medicaid Hospital Coverage and Limitations Handbook the appropriate revenue center codes that best describe the accommodations, services, and items applicable to this hospitalization. When revenue code 0471 is billed on an inpatient claim, it must be accompanied by one of the following hearing screening CPT codes in Form Locator 44: 92585, 92587, 92585-TC, 92587-TC. **Outpatient**: Select from Appendix B in the Florida Medicaid Hospital Coverage and Limitations Handbook the appropriate revenue center codes that best describe the services and items applicable to this outpatient encounter. Each revenue center code, other than 0300 - 0314, will be reimbursed only once on the claim. Enter the number of units in Form Locator 46. Laboratory and pathology revenue center codes 0300 through 0314 may be entered more than once on the claim; however, these revenue codes must be accompanied by a 5-digit CPT-4 lab code found in the Outpatient Hospital Laboratory Services Fee Schedule and entered in Form Locator 44 of the claim form. Same revenue codes used more than once require a different CPT-4 lab code in Form Locator 44 each time. Note: See Form Locator 44 for other CPT code entry requirements when certain other revenue center codes are billed. **Hospice**: See Chapter 3 in the Florida Medicaid Hospice Coverage and Limitations Handbook for covered hospice revenue center codes. Use revenue center code 0657 to identify provider charges for services furnished to hospice patients by physicians employed by the hospice or receiving compensation from the hospice. When billing revenue code 0657, enter the corresponding 5-digit CPT-4 procedure code in Form Locator 44.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
42 (Continued)	**Revenue Code**	**Freestanding Dialysis Centers**: Revenue center codes 0821 and 0831 represent covered services. Revenue Codes 0821 and 0831 may be billed only once on the claim. Enter the number of units in Form Locator 46. Chapter 3 of the Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations Handbook lists the drugs that are billed with revenue center codes 0634, 0635, and 0636. When billing for a drug, enter the corresponding five-digit HCPCS procedure code in Form Locator 44. Use revenue code 0636 when dispensing AHCA-specified charges for drugs and biologics that are billed under revenue code 0636 (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) require specific identification. If using a HCPCS to describe the drug, enter the corresponding five-digit HCPCS procedure code in Form Locator 44. Enter the specific service units reported in hundreds (100s); rounded to the nearest hundred; do not use a decimal. Note: The Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations 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-4.105, F.A.C. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter the appropriate revenue code: 0101 – Long Term Care days 0185 – Hospital leave days (Bed-hold days) 0182 – Home leave days (Therapeutic bed-hold days)

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
43	**Revenue Code Description**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter a written description of the related revenue categories included on this bill. Line 23: Page ___ of ___ - On multiple page claims, all required fields must be completed on each page of the claim. Enter the page number and the total number of pages on the bottom of each claim page. For example, the first page would be numbered page 1 of 2, the second page, page 2 of 2. **Outpatient:** Florida Medicaid is collecting NDC information on Centers for Medicare and Medicaid Services designated, physician administered drugs in the outpatient hospital setting. The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See the instructions below for entering the NDC. **Freestanding Dialysis Centers:** The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See the instructions below for entering the NDC. Florida Medicaid will reimburse freestanding dialysis centers only for drugs for which the manufacturer has a federal rebate agreement per SEC. 1927. *[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." **Instructions for Entering the NDC:** When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in Form Locator 43 for the specified detail line. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units. 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

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
44	**HCPCS/Rates/HIPPS Rate Codes**	**Inpatient**: Required for inpatient newborn hearing screening services. When revenue code 0471 is entered in Form Locator 42, enter the appropriate hearing screening CPT code that best describes the service rendered. They are 92585, 92587, 92585-TC, and 92587-TC. For details on inpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750, and 0790, see the instructions for Form Locator 74. **Outpatient**: Enter the five-digit CPT-4 lab code from the Outpatient Hospital Laboratory Fee Schedule when billing for laboratory revenue codes (0300-0314). Do not bill radiology services with CPT codes. Radiology services performed by hospitals are billed by revenue code only. Revenue codes 0360, 0361, 0722, 0750, and 0790 require the entry of a HCPCS CPT procedure code. Revenue code 0471 requires the entry of one of the following newborn hearing screening codes in this form locator: 92585, 92587, 92588, 92585-TC, 92587-TC, or 92588-TC. Revenue code 0451 requires the entry of CPT code 99281 (emergency room screening and evaluation). Bill 0451 (99281) when the recipient had to be screened per EMTALA but required no further emergency room services. Centers for Medicare and Medicaid Services designated, physician administered drugs, for which the National Drug Code is reported, require the entry of the appropriate HCPCS code. **Freestanding Dialysis Centers**: Claims for the administration of Erythropoietin (Epogen, EPO) require the entry of the five-digit injection HCPCS code. When billing for drugs and biologicals, the 11-digit National Drug Code (NDC) is required in Form Locator 43 along with the five-digit HCPCS code in Form Locator 44. (See Form Locator 43 for details instructions on entering the 11-digit NDC on the claim.) **Hospice**: When billing revenue center code 0657, enter the corresponding five-digit CPT-4 code that is in the Florida Medicaid Hospice Coverage and Limitations Handbook. No other codes are covered. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry is required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
45	**Service Date**	**Required on outpatient claims**. Lines 1 – 22: On each line, enter the date of service. Line 23: On each page, enter the date the bill was created or prepared for submission in MMDDYY format.
46	**Units of Service**	This form locator will accept up to seven characters. Leading zeros are not required. **Inpatient**: Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day. **Outpatient**: Enter the units of service for each revenue code. **Hospice**: Enter the number of units of service for each type of service. Units are measured in days for codes 0651, 0655, 0656 and 0659; in hours for code 0652; and in procedures for 0657. **Freestanding Dialysis Centers**: Enter the units of service for the revenue center code(s). For revenue center codes 0821 and 0831, units are measured in the number of dialysis treatments the patient received in the billing period. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter the number of days associated with each revenue code. Medicaid reimburses the date of admission, but not the date of discharge. Include the date of admission, but do not include the date of discharge in the total number of days. If the recipient is admitted and discharged on the same day, count it as one day.
47	**Total Charges**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers:** Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Do not deduct the patient responsibility. Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001. For Medicare crossover claims (level of care X), compute the total charge using the Medicare rate instead of the Medicaid per diem. If the Medicare rate for a recipient changed during the month, use the weighted average Medicare rate (weighted based on the number of days each rate is paid).

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
48	**Non-Covered Charges**	**Inpatient**: No entry required. **Outpatient, Hospice, and Freestanding Dialysis Centers**: Enter the total payment received or expected to be received from a primary insurance payer identified in Form Locator 50A. Enter each portion of the payment applicable to each code in Form Locator 48. Enter the total amount payment received or expected to be received from a primary insurance payer on the final page of the claim in Line 23. If the primary insurance payer other than Medicare pays a lump sum payment, enter a prorated amount on each line. If there is more than one other private payer, lump all amounts together in Form Locator 48 and attach each company's Explanation of Benefits or remittance. Electronic software allows separate entries on an outpatient claim for primary, secondary, and tertiary payer payments. If billing on a paper claim and there is more than one private payer, attach documentation to show how much each payer paid for each line item. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry is required.
49	**Unlabeled**	No entry required.
50 A-C	**Payer Name**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter "Florida Medicaid" for the Medicaid payer identification. Enter the name of the third party payer if applicable: 50A–Primary Payer. 50B–Secondary Payer. 50C–Tertiary Payer.
51 A-C	**Health Plan ID**	For Medicaid, leave blank. If the health plan in Form Locator 50 has a number, report the number in 51 A, B, or C depending on whether the insurance is primary, secondary, or tertiary. If the number is unknown, leave blank.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
52 A-C	**Release of Information**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Indicate whether the patient or patient's legal representative has signed a statement permitting the provider to release data to other organizations. The Release of Information is limited to the information carried in this claim. A= Primary B= Secondary C= Tertiary Code Structure: I = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. (Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.) Y = Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. (Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.)
53 A-C	**Assignment of Benefits**	No entry required.
54 A-C	**Prior Payments**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs):** Enter the amount that the provider has received toward payment of this bill prior to the billing date on this claim. Do not put the Medicaid amount due in this form locator. **Inpatient and Outpatient**: If no payment was received or if the service was denied, attach a copy of the EOB from the insurance carrier with the reason for the denial.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
55 A-C	**Estimated Amount Due**	No entry required.
56	**NPI**	The National Provider Identifier (NPI) is a unique HIPAA-mandated number assigned to the provider submitting the bill. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57. If the 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 B3 and the taxonomy code in Form Locator 81. Entry of the NPI on paper claims is optional. Florida Medicaid prefers that the provider continue to enter Medicaid provider numbers on paper claims.
57 A-C	**Other Provider ID**	Use if an identification number other than NPI is being reported. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57.
58 A-C	**Insured's Name**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter the insured's last name, first name, and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility. If the recipient is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
59 A-C	**Patient's Relationship**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs):** Enter the code indicating the relationship of the patient to the identified insured. Line A: Primary Payer, Required Line B: Secondary Payer, Situational Line C: Tertiary Payer, Situational Code Structure: 01 = Spouse 18 = Self 19 = Child 21 = Unknown
60 A-C	**Insured's Unique ID**	**Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter all of the insured's unique identification numbers assigned by any payer organizations. The recipient's ten-digit Medicaid ID number must be verified and entered. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C. If Medicaid is primary, enter the recipient's Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID number in Form Locator 60B.
61 A-C	**Insurance Group Name**	No entry required.
62 A-C	**Insurance Group Number**	No entry required.
63 A-C	**Treatment Authorization Code**	**Inpatient - MediPass**: If a recipient under 21 is in the Children's Medical Services' (CMS) Network and the MediPass primary care physician authorized the services being billed, enter the 9-digit MediPass authorization number that was given to the hospital in Form Locator 63A. This number is different from the 10-digit prior authorization number issued by the PRO for inpatient services. If the recipient in the CMS Network is admitted due to an emergency, no MediPass authorization number is required in this form locator. This requires type of admission code "1" or "5" in Form Locator 14. A MediPass authorization number is **not** required for any type of inpatient admission for any other category of recipient, except for children in the CMS Network.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
63 A-C (Continued)	**Treatment Authorization Code**	**Inpatient Admissions**: If an inpatient admission requires an authorization from the PRO, enter the prior authorization number that covers the authorized days in Form Locator 63A, if Medicaid is the primary payer, or in Form Locator 63B, if Medicaid is the secondary payer. Most inpatient admissions require authorization from the PRO before Medicaid payment can be made. However, there are several exemptions from inpatient authorization. An exemption from authorization allows Medicaid to pay an inpatient claim without authorization from the PRO and without a prior authorization number on the claim form. Note: See Chapter 3 in this handbook for information on the types of admissions and recipient categories that require inpatient authorization and the listing of recipient categories and circumstances that are exempt from authorization. **Inpatient - Psychiatric or Substance Abuse**: When the admitting and primary diagnosis code is in the range of 290–314.9 or 648.30–648.44, prior authorization by the psychiatric PRO is required. Enter the prior authorization number that covers this hospitalization in Form Locator 63A, if Medicaid is the primary payer, or in 63B, if Medicaid is the secondary payer. Note: See Chapter 3 in this handbook for information on inpatient psychiatric or substance abuse authorization requirements. **Outpatient**: Outpatient services to recipients enrolled in MediPass require authorization from the MediPass primary care physician before services can be rendered, if the outpatient encounter is not an emergency. Enter the MediPass authorization number in Form Locator 63A if Medicaid is the primary payer or in 63B if Medicaid is the secondary payer. MediPass authorization is not required for true emergencies. This is indicated by the code entry of “1” or “5” for type of admission in Form Locator 14. It is also not required for Emergency Room Screening and Evaluation Services required by the Emergency Medical Treatment and Active Labor Act (EMTALA), billed using revenue code 0451 with HCPC (99281). **Hospice**: No entry required. **Freestanding Dialysis Centers**: No entry required. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
64 A-C	**Document Control Number**	No entry required. If the claim is an adjustment or void of a previously paid claim, enter the 13-digit Internal Control Number in Form Locator 80 on Line 2. For a claim that was processed prior to July 1, 2008 that has a 17-digit Transaction Control Number (TCN), enter the TCN.
65 A-C	**Employer Name (of the Insured)**	**Inpatient, Outpatient, Hospice, and Freestanding Dialysis Centers**: Enter the name of the employer who provides or might provide health care coverage for the patient.
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported: 9 – Ninth Revision 0 – Tenth Revision
67	**Principal Diagnosis**	This Form Locator is optional; it is not entered in the Florida Medicaid Management Information System. **Inpatient and Hospice**: Enter the most specific fourth and fifth digit ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization or need for hospice care) that exists at time of admission or develops subsequently that has an effect on the length of stay. Psychiatric admissions require the entry of a diagnosis in the range of 290-314.9 or 648.30-648.44 in this form locator and in Form Locator 69. A prior authorization number from the psychiatric PRO is required when the principal diagnosis is in the ranges noted here. If Medicaid is primary, the psychiatric PRO issued PA number is entered in Form Locator 63A; if Medicaid is secondary, the PA number is entered in Form Locator 63B. **Outpatient**: Enter only the most specific ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the use of hospital services that exists at time of service). **Freestanding Dialysis Centers**: Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for dialysis services. For example, diagnosis code 585.6 for end stage renal disease. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for long term care.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
67 (Continued)	**Principal Diagnosis**	This Form Locator is optional; it is not entered in the Florida Medicaid Management Information System. **Inpatient and Outpatient: Present on Admission (POA) Indicator:** The POA Indicator applies to diagnosis codes, not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The five reporting options for all diagnosis reporting are as follows: Y = Yes N = No U = No Information in the Record W = Clinically Undetermined (Unreported—Not Used) = Exempt from POA Reporting

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
67 A-Q	**Other Diagnoses**	Enter diagnoses that are other than the principle diagnosis. **Inpatient**: Enter the most specific ICD diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or developed subsequently and had an effect on the treatment received during the length of stay. **Outpatient**: Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service. **Inpatient and Outpatient: Present on Admission (POA) Indicator:** The POA Indicator applies to diagnosis codes, not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The five reporting options for all diagnosis reporting are as follows: Y = Yes N = No U = No Information in the Record W = Clinically Undetermined (Unreported—Not Used) = Exempt from POA Reporting **Hospice**: No entry required. **Freestanding Dialysis Centers**: Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required. **Special Circumstances When Diagnosis Codes are NOT Required on Outpatient Claims**: Diagnosis codes are not required on outpatient claims when the type of bill is 141 (hospital-referenced diagnostic services) or when either of the following: • The only revenue center codes on the claim are in the range 0300-0307. • The only revenue center codes on the claim are any one or any combination of the following (with any Type of Admission code): 0310, 0311, 0312, 0314, 0320, 0321, 0322, 0323, 0324, 0340, 0341, 0400, 0401, 0402, 0460, 0610, 0611, 0612, 0730, 0731, 0740.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
68	**Unlabeled**	No entry required.
69	**Admitting Diagnosis**	**Inpatient**: Required for all inpatient claims and claims with Type of Bills (Form Locator 4): 011X, 012X, 018X and 021X. The presence of an admitting diagnosis in 290–314.9, or 648.30–648.44 range, psychiatric or substance abuse, indicates that the inpatient services needed authorization by the psychiatric PRO. **Outpatient**: Required for outpatient to report the presenting symptom (diagnosis) and the reason for the patient's visit on claims that contain emergency services. **Hospice, Freestanding Dialysis, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.
70 a-c	**Patient's Reason for Visit Code**	**Outpatient:** Enter the diagnosis codes describing the patient's reason at the time of the outpatient registration. This is required for all unscheduled outpatient visits as defined when the following occurs: Form Locator 4, Type of Bill 013X or 085X; Form Locator 14, Type of Admission codes 1, 2, or 5; and Form Locator 42, Revenue Codes 045X, 0516, 0526 or 0762 (Observation Room). **Inpatient, Hospice, Freestanding Dialysis, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.
71	**PPS Code**	No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
72 a-c	**External Cause of Injury Code**	No entry required. **Inpatient and Outpatient**: Enter the ICD diagnosis code pertaining to external cause of injuries, poisonings, or adverse effect. Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. **Inpatient and Outpatient: Present on Admission (POA) Indicator:** The POA Indicator applies to diagnosis codes, not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The five reporting options for all diagnosis reporting are as follows: Y = Yes N = No U = No Information in the Record W = Clinically Undetermined (Unreported—Not Used) = Exempt from POA Reporting **Hospice, Freestanding Dialysis, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs):** No entry is required.
73	**Unlabeled**	No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
74	**Principal Procedure Code and Date**	**Inpatient**: Enter the code identifying the principal ICD surgical or obstetrical procedure and the date on which either was performed. Enter the date in MMDDYY format. False labor does not require a procedure code. A first surgical procedure code is required in this form locator when one of the following revenue codes is reported: 0360, 0361, 0722, 0750, or 0790. **Outpatient**: For details on outpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750, or 0790, see the instructions for Form Locator 44. **Hospice**: No entry required. **Freestanding Dialysis Centers**: No entry required. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.
74 a-e	**Other Procedure Codes and Dates**	**Inpatient**: Enter the codes identifying all significant procedures, other than the principal procedure, performed during the billing period covered by this bill and the dates on which the procedures were performed. **Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.
75	**Unlabeled**	No entry required.
76	**Attending Physician Name and Identifiers**	Enter the identifying information for the attending physician (the physician primarily responsible for the care of the patient) or the resident physician. Identifying information of Advanced Registered Nurse Practitioners (ARNPs) may also be reported in this form locator if they were primarily responsible for services in the hospital setting. Entry of the NPI is optional; but the Qualifier 0B (for state license number) must be entered in the small field to the right of "QUAL", and the state license number must be entered in the larger field. Enter the license information in the following manner: ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending physician ID number.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
77	**Operating Physician Name and Identifiers**	Required when a surgical procedure code is listed on the claim. Enter the identifying information for the surgeon. Entry of the NPI is optional, but the Qualifier 0B (for state license number) and the state license number must be entered. Enter the license information in the following manner: ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending physician ID number.
78-79	**Other Provider Name and Identifiers**	Enter the identifying information for the other provider. Entry of the NPI is optional, but the Qualifier 0B (for state license number) and the state license number must be entered. Enter the license information in the following manner: ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending physician ID number. **Inpatient and Outpatient**: If more than one physician performed the principal procedure or a different individual performed a secondary surgical procedure, report the other provider. **Outpatient**: If the referring provider is different than the attending physician, report the referring physician's information. **Hospice**: No entry required. **Freestanding Dialysis Centers**: No entry required. **Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs)**: No entry required.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
80	**Remarks (Financial Classification Code)**	This field has four lines. Line 1: Financial Classification Code. Enter "FC" followed by the three-digit "Financial Classification Code" in line 1 of Form Locator 80. This code identifies the relationship of the payers indicated in Form Locators 50 A-C. The FC code is as follows: 1st position = Form Locator 50A primary payer code 2nd position = Form Locator 50B secondary payer code 3rd position = Form Locator 50C tertiary payer code Payer Codes: 0 No payer 1 Medicaid 2 Private Insurance 3 Blue Cross 4 Employer or Union 5 Medicare Part B 6 Other State Agency 8 No hospice patient resp. 9 Other (The FC code may be entered on the same line as "Remarks" or the line below.) Example of FC codes: 100 – Straight Medicaid claim, claim with third party insurance denial attached, claim to which third party insurance applied all the payment to the deductible, and a hospice claim with patient responsibility. 180 – Claim with no hospice patient responsibility. 210 – Claim with private insurance as the primary payer over Medicaid. 310 – Claim with private Blue Cross insurance as the primary payer over Medicaid. 510 – Medicare Part B-Only (Inpatient Claim). 910 – Medicare crossover claims with other third party payments. Line 2: If you are adjusting or voiding the claim, enter the Internal Control Number (ICN) in line 2. For a claim that was processed prior to July 1, 2008 that has a 17-digit Transaction Control Number (TCN), enter the TCN. Enter the Financial Classification Code that indicates that you are adjusting or voiding the claim in line 1. (Be sure the correct type of bill code is entered in Form Locator 4.) See Appendix A for the Internal Control Number (ICN) Regions Codes. Line 3: Enter "Crossover" on Medicare crossover claims without TPL payment.

How to Complete the UB-04 Claim Form, continued

FORM LOCATOR	TITLE	ACTION
81 a-c	**Code-Code Field**	If an NPI is entered in Form Locator 56 and the provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the provider must enter qualifier code B3 and the taxonomy code in this Form Locator.
81 d	**Code-Code Field**	**Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs):** In the first field, enter Qualifier Code 02. In the second field, enter the established level of care (LOC) code to indicate the type of care that the recipient has been determined to require: 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 In the third field, enter the facility's per diem. For level of care X, enter the respective Medicare per diem
	Claim Certification	Because the UB-04 claim form does not have the provider's 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 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.

Illustration 1-3. Sample Completed Inpatient UB-04 Claim Form

1 ABC Hospital
123 Palm Street
Anywhere, FL 33333-1234
(850) 999-8888

2

3a PAT CNTL # 28
b MED REC #

4 TYPE OF BILL 0111

5 FED TAX NO. 58-1234567

6 STATEMENT COVERS PERIOD FROM 040108 THROUGH 040308

7

8 PATIENT NAME a
b Resident, Florida A

9 PATIENT ADDRESS a 103 Main St.
b Anywhere c FL d 33333 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
04291972	F	040108	10	2	7	19	01	C1		

31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 SPAN FROM	35 SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 SPAN FROM	36 SPAN THROUGH	37
a 10	040108													a
b														b

38

	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0121	Semi-Private Room			002	1400.00		1
2	0170	Nursery			002	900.00		2
3	0250	Pharmacy			032	480.00		3
4	0300	Laboratory			009	800.00		4
5	0360	Operating Room Services			001	800.00		5
6	0370	Anesthesia			001	250.00		6
7	0450	Emergency Room			001	150.00		7
8	0720	Labor/Delivery Room			001	175.00		8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16		Hospital INPATIENT SAMPLE						16
17								17
18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE	043008	TOTALS	4455.00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER / PRV ID	
A	Florida Medicaid		Y				1234567891	010000100	A
B									B
C									C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A	18	7412345922		A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	8119900441		A
B			B
C			C

66 DX 9: 669.7 Y | 660.1 Y | 662.0 Y | 68

69 ADMIT DX 669.7 | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE	74 PRINCIPAL PROCEDURE DATE	a. OTHER PROCEDURE CODE	a. OTHER PROCEDURE DATE	b. OTHER PROCEDURE CODE	b. OTHER PROCEDURE DATE	75
74.0	040108					
c. OTHER PROCEDURE CODE	c. OTHER PROCEDURE DATE	d. OTHER PROCEDURE CODE	d. OTHER PROCEDURE DATE	e. OTHER PROCEDURE CODE	e. OTHER PROCEDURE DATE	

80 REMARKS FC 100

81 CC a b c d

76 ATTENDING NPI 9076543210 QUAL OB ME9999999
LAST Smith FIRST Jane
77 OPERATING NPI 9876543210 QUAL OB ME1234567
LAST Jones FIRST John
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

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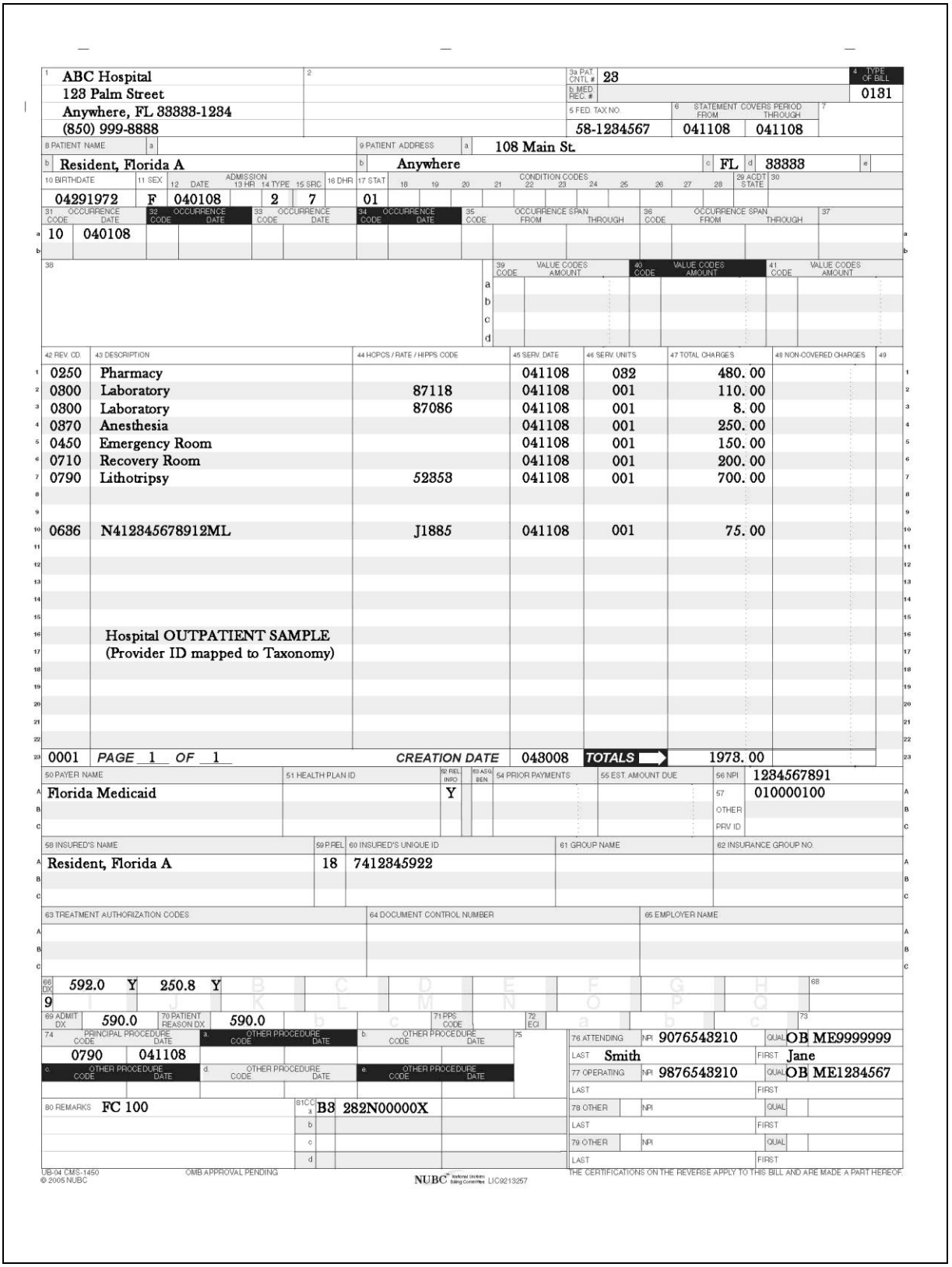
Illustration 1-4. Sample Completed Outpatient UB-04 Claim Form



1 ABC Hospital
123 Palm Street
Anywhere, FL 33333-1234
(850) 999-8888

2

3a PAT. CNTL. # 23
b. MED. REC. #

4 TYPE OF BILL 0131

5 FED. TAX NO. 58-1234567

6 STATEMENT COVERS PERIOD FROM 041108 THROUGH 041108

7

8 PATIENT NAME a b Resident, Florida A

9 PATIENT ADDRESS a 108 Main St. b Anywhere c FL d 33333 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
04291972	F	040108		2	7		01													

31 CODE	31 DATE	32 CODE	32 DATE	33 CODE	33 DATE	34 CODE	34 DATE	35 CODE	35 SPAN FROM	35 SPAN THROUGH	36 CODE	36 SPAN FROM	36 SPAN THROUGH	37
a 10	040108													a
b														b

38

39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a					
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0250	Pharmacy		041108	032	480.00		1
2	0300	Laboratory	87118	041108	001	110.00		2
3	0300	Laboratory	87086	041108	001	8.00		3
4	0370	Anesthesia		041108	001	250.00		4
5	0450	Emergency Room		041108	001	150.00		5
6	0710	Recovery Room		041108	001	200.00		6
7	0790	Lithotripsy	52353	041108	001	700.00		7
8								8
9								9
10	0636	N412345678912ML	J1885	041108	001	75.00		10
11								11
12								12
13								13
14								14
15								15
16		Hospital OUTPATIENT SAMPLE						16
17		(Provider ID mapped to Taxonomy)						17
18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE	043008	TOTALS	1978.00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID	
A	Florida Medicaid		Y				1284567891	010000100	A
B									B
C									C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A	18	7412345922		A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX: 592.0 Y 250.8 Y 9 — A B C D E F G H I J K L M N O P Q — 67 — 68

69 ADMIT DX 590.0 — 70 PATIENT REASON DX 590.0 — a b c — 71 PPS CODE — 72 ECI — a b c — 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
0790	041108					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS FC 100

81CC a B3 282N00000X
b
c
d

76 ATTENDING	NPI 9076543210	QUAL OB	ME9999999
LAST Smith		FIRST Jane	
77 OPERATING	NPI 9876543210	QUAL OB	ME1234567
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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Illustration 1-5. Sample Completed Hospice UB-04 Claim Form

1	All Florida Hospice 123 Elm Street Anywhere, FL 32399 (850) 911-0000
2	
3a PAT. CNTL #	012345
b. MED. REC. #	
4 TYPE OF BILL	0813
5 FED. TAX NO.	58-1234567
6 STATEMENT COVERS PERIOD FROM / THROUGH	040107 / 043007
8 PATIENT NAME	b Resident, Florida A
9 PATIENT ADDRESS	a 103 Main St. b Anywhere c FL d 32399
10 BIRTHDATE	042772
11 SEX	F
12 ADMISSION DATE	021007
15 SRC	1
17 STAT	30
39 VALUE CODES CODE / AMOUNT	a 31 / 45.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0659	Hospice Room and Board			30	2154.00		
0657	Hospice Physician Services	99211		10	120.00		
0001	PAGE ____ OF ____	CREATION DATE	043007	TOTALS	2274.00		

50 PAYER NAME	A Florida Medicaid
52 REL. INFO	Y
56 NPI	1234567891
57 OTHER PRV ID	412345600
58 INSURED'S NAME	A Resident, Florida A
59 P. REL	18
60 INSURED'S UNIQUE ID	7432345922
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	9
67	157.9
76 ATTENDING NPI	9876543210
QUAL	OB ME7777777
LAST / FIRST	Smith / Jane
80 REMARKS	FC 100

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Illustration 1-6. Sample Completed Freestanding Dialysis Center UB-04 Claim

Field	Entry
1	Dialysis Center 123 Elm Street Anywhere, FL 32333-1234 (855) 999-8888
2	
3a PAT. CNTL #	23
b. MED. REC. #	
4 TYPE OF BILL	0721
5 FED. TAX NO.	58-1234567
6 STATEMENT COVERS PERIOD FROM / THROUGH	080108 / 082508
7	
8 PATIENT NAME	b Resident, Florida A
9 PATIENT ADDRESS	a 108 Main St. b Anywhere c FL d 33333
10 BIRTHDATE	04291972
11 SEX	F
12 ADMISSION DATE / 13 HR / 14 TYPE / 15 SRC	15 SRC: 2
16 DHR / 17 STAT	
18–28 CONDITION CODES	18: 71
29 ACDT STATE / 30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37 / 38	
39–41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0821	Hemodialysis			015	4500. 00		
0636	N412345678900GRS	J2916		5	35. 65		
	Freestanding DIALYSIS SAMPLE						
0001	PAGE 1 OF 1	CREATION DATE	043008	TOTALS	4535. 65		

Field	Entry
50 PAYER NAME	A Florida Medicaid
51 HEALTH PLAN ID	
52 REL. INFO	Y
53 ASG. BEN.	
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	
56 NPI	1234567891
57 OTHER PRV ID	150000100
58 INSURED'S NAME	A Resident, Florida A
59 P. REL	18
60 INSURED'S UNIQUE ID	7412345922
61 GROUP NAME	
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	9
67	585.6
67A	275.4
68	
69 ADMIT DX / 70 PATIENT REASON DX / 71 PPS CODE / 72 ECI / 73	
74 PRINCIPAL PROCEDURE CODE / DATE; a–e OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING	NPI 9076543210 QUAL OB ME9999999 LAST Smith FIRST Jane
77 OPERATING	NPI QUAL LAST FIRST
78 OTHER	NPI QUAL LAST FIRST
79 OTHER	NPI QUAL LAST FIRST
80 REMARKS	FC 100
81CC a–d	

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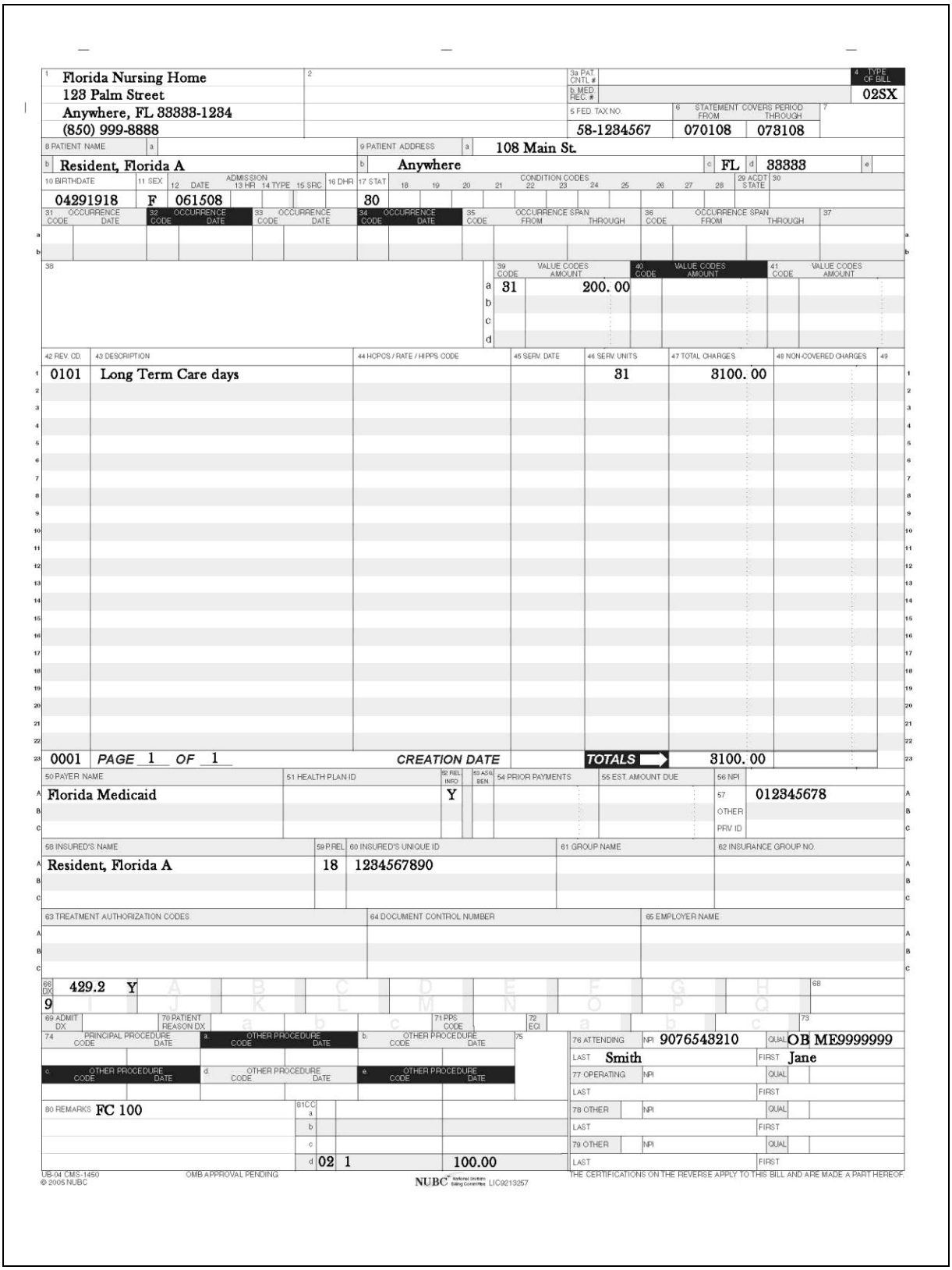
Illustration 1-7. Sample Completed Nursing Facility Claim Form



1 Florida Nursing Home
123 Palm Street
Anywhere, FL 33333-1234
(850) 999-8888

2

3a PAT. CNTL #
b. MED. REC. #

4 TYPE OF BILL: 02SX

5 FED. TAX NO.: 58-1234567

6 STATEMENT COVERS PERIOD: FROM 070108 THROUGH 073108

7

8 PATIENT NAME: a
b Resident, Florida A

9 PATIENT ADDRESS: a 108 Main St.
b Anywhere
c FL
d 33333
e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
04291918	F	061508					30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	31	200.00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0101	Long Term Care days			31	3100.00		1
2								2
3								3
4								4
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18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE		TOTALS	3100.00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	Florida Medicaid		Y				57 012345678	A
B							OTHER	B
C							PRIV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A	18	1234567890		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX: 9
A 429.2 Y
B C D E F G H
I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX: a b c
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

80 REMARKS: FC 100

81CC			
a			
b			
c			
d	02	1	100.00

76 ATTENDING NPI 9076543210 QUAL OB ME9999999
LAST Smith FIRST Jane
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450
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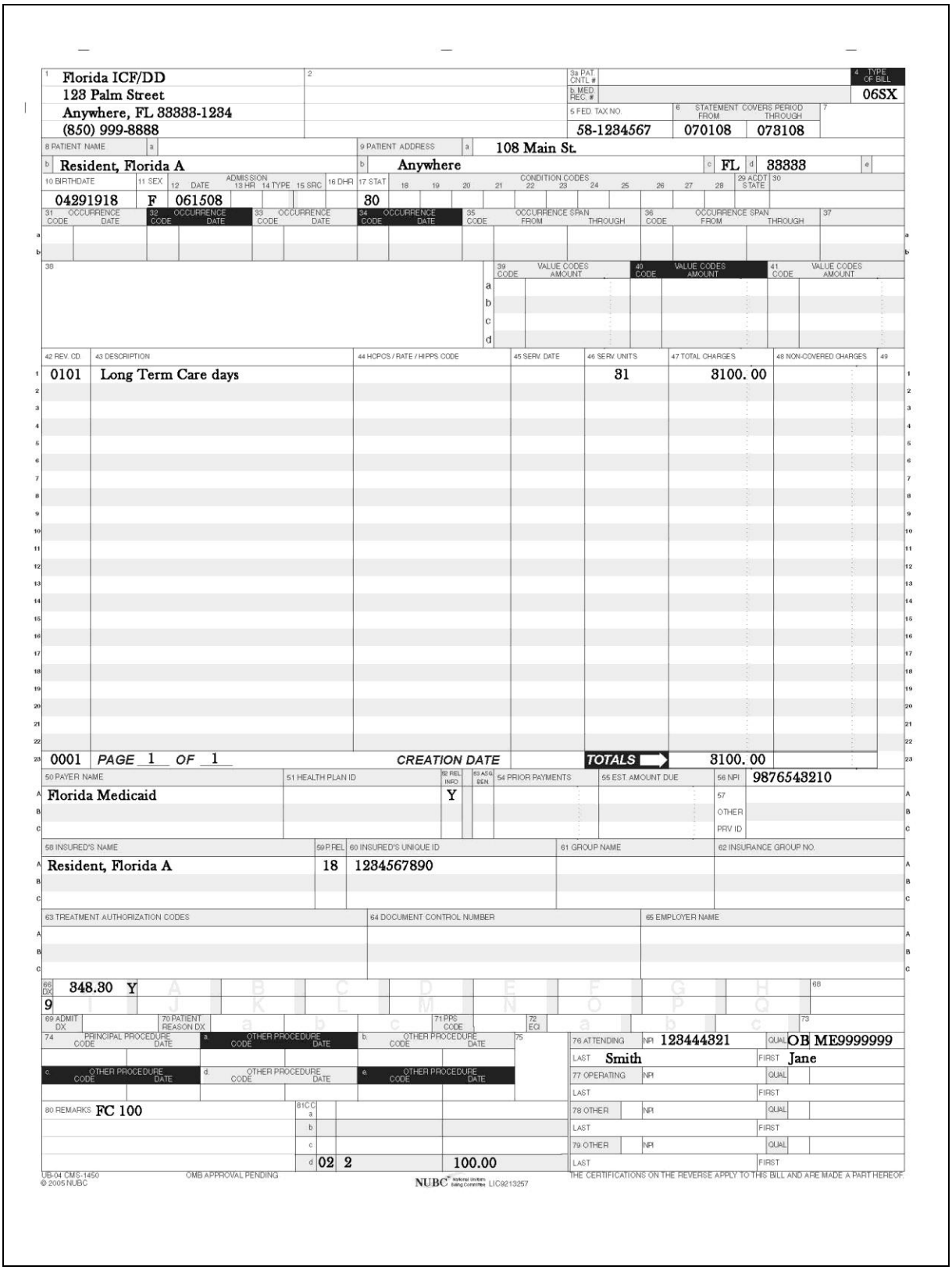
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Illustration 1-8. Sample Completed ICF/DD Claim Form



1 Florida ICF/DD
123 Palm Street
Anywhere, FL 33333-1234
(850) 999-8888

2

3a PAT. CNTL #
b MED. REC. #

4 TYPE OF BILL: 06SX

5 FED. TAX NO.: 58-1234567

6 STATEMENT COVERS PERIOD: FROM 070108 THROUGH 073108

7

8 PATIENT NAME: b Resident, Florida A

9 PATIENT ADDRESS: a 108 Main St. b Anywhere c FL d 33333 e

10 BIRTHDATE: 04291918

11 SEX: F

12 ADMISSION DATE: 061508

13 HR

14 TYPE

15 SRC

16 DHR

17 STAT: 30

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES

29 ACDT STATE

30

31 OCCURRENCE CODE DATE

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE SPAN CODE FROM THROUGH

36 OCCURRENCE SPAN CODE FROM THROUGH

37

38

39 VALUE CODES CODE AMOUNT

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0101	Long Term Care days			31	3100.00		
0001	PAGE 1 OF 1	CREATION DATE		TOTALS	3100.00		

50 PAYER NAME: A Florida Medicaid

51 HEALTH PLAN ID

52 REL INFO: Y

53 ASG BEN

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56 NPI: 9876543210

57 OTHER PRV ID

58 INSURED'S NAME: A Resident, Florida A

59 P REL: 18

60 INSURED'S UNIQUE ID: 1234567890

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

66 DX: 9 348.30 Y

67 A B C D E F G H I J K L M N O P Q

68

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c

73

74 PRINCIPAL PROCEDURE CODE DATE

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

75

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 123444321 QUAL OB ME9999999
LAST Smith FIRST Jane

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS: FC 100

81CC a b c d 02 2 100.00

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NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 copy legible?
- ❑ Were instructions in the handbook followed? Some fields are not self-explanatory or may be used for other purposes.
- ❑ Are the provider name and number entered?
- ❑ Are attachments required? Claims cannot be paid without the required attachments.
- ❑ Is the MediPass authorization number included for services that require the MediPass primary care provider's approval? Without this number, the claim will be denied.
- ❑ Is the PRO authorization number present for inpatient admissions that require PRO approval? Without this number, the claim will be denied.
- ❑ Is 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 UB-04, adjustment UB-04, or a void UB-04. 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 for each claim type being mailed. Printed addresses speed up post office processing.
- ❑ Claims mailed in a large envelope or "flat" need to 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 UB-04 **Resubmittal UB-04**	UB-04 Claims P.O. Box 7062 Tallahassee, FL 32314-7062
UB-04 Crossover	UB-04 Crossover Claims P.O. Box 7064 Tallahassee, FL 32314-7064
Adjustments and Voids	Adjustments and Voids P.O. Box 7080 Tallahassee, FL 32314-7080
Exceptions to Filing Time Limits	Area Medicaid Office See Appendix C in the Florida Medicaid Provider General Handbook for the address.
Authorization Request	Prior Authorizations P.O. Box 7090 Tallahassee, FL 32314-7090

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. Information is also available by calling the EDI Help Desk at 800-289-7799 and selecting Option 3 or calling 866-586-0961.

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:

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. • Suspended: 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)
- Groups of Four Different Claim Types Applicable to UB-04 Claims:
  - ⇒ Outpatient
  - ⇒ Inpatient
  - ⇒ Long Term Care
  - ⇒ Medicare A Crossover
- 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)

Claims are grouped into four claim type groups applicable to UB-04 claims. Each of the claim types will report claims falling in any of the four disposition categories of paid, denied, in process, or adjusted claims:

Outpatient
CRA-OPPD-R, Paid
CRA-OPDN-R, Denied
CRA-OPSU-R, In Process
CRA-OPAD-R, Adjustments

Inpatient
CRA-IPPD-R, Paid
CRA-IPDN-R, Denied
CRA-IPSU-R, In Process
CRA-IPAD-R, Adjustments

Long Term Care (Nursing Facility and ICF/DD)
CRA-LTPD-R, Paid
CRA-LTDN-R, Denied
CRA-LTSU-R, In Process
CRA-LTAD-R, Adjustments

Medicare Crossover A
CRA-XAPD-R, Paid
CRA-XADN-R, Denied
CRA-XASU-R, In Process
CRA-XAAD-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 claim type group and disposition, e.g., Long Term Care - Denied. All claims of the same type and 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 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 Outpatient Claims Paid

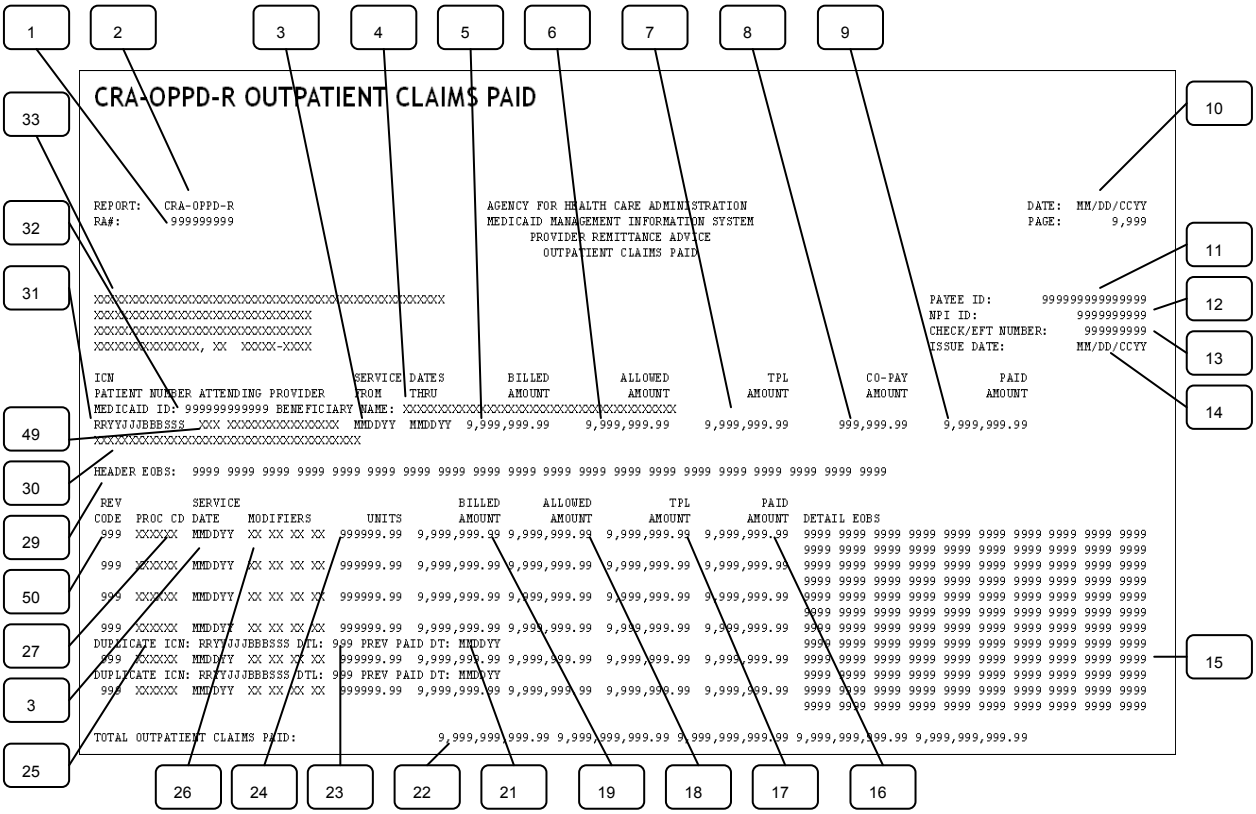


Illustration 2-2. Sample Outpatient Claims Denied

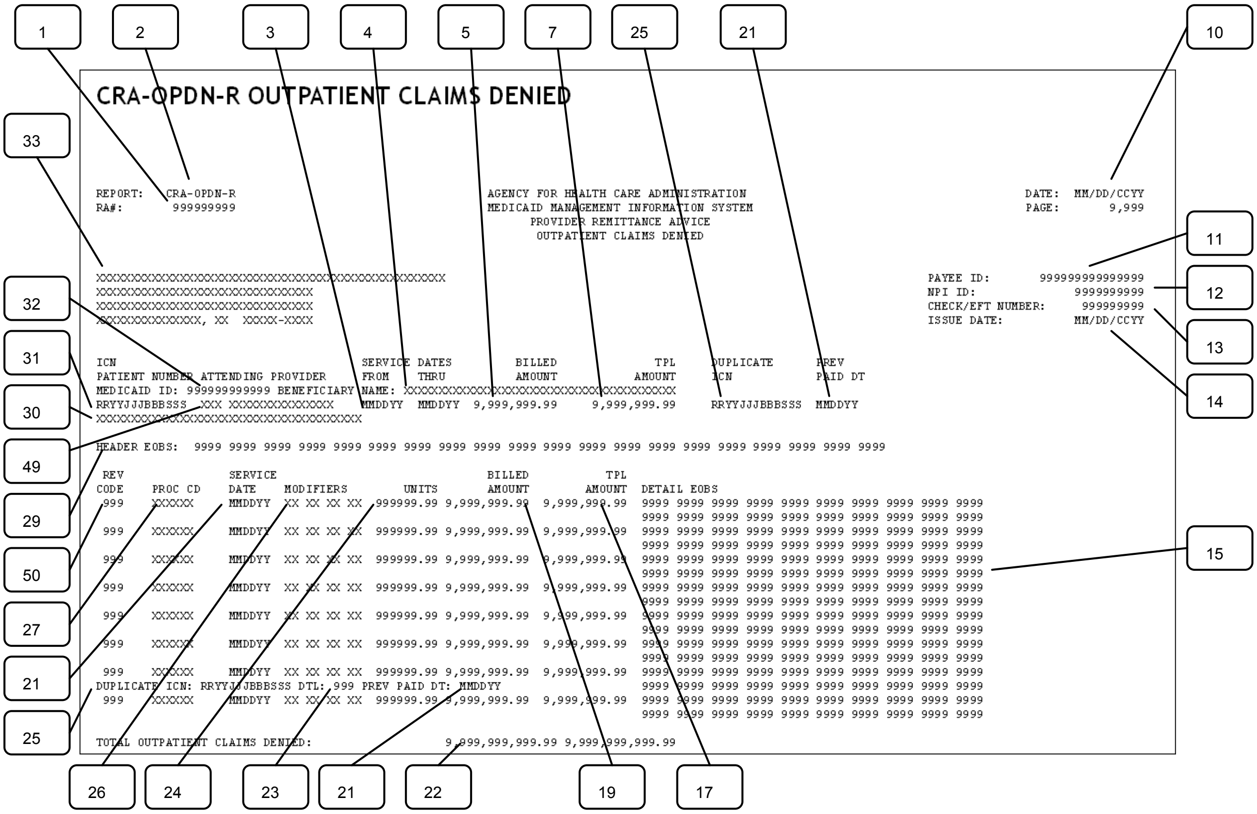


Illustration 2-3. Sample Outpatient Claims in Process

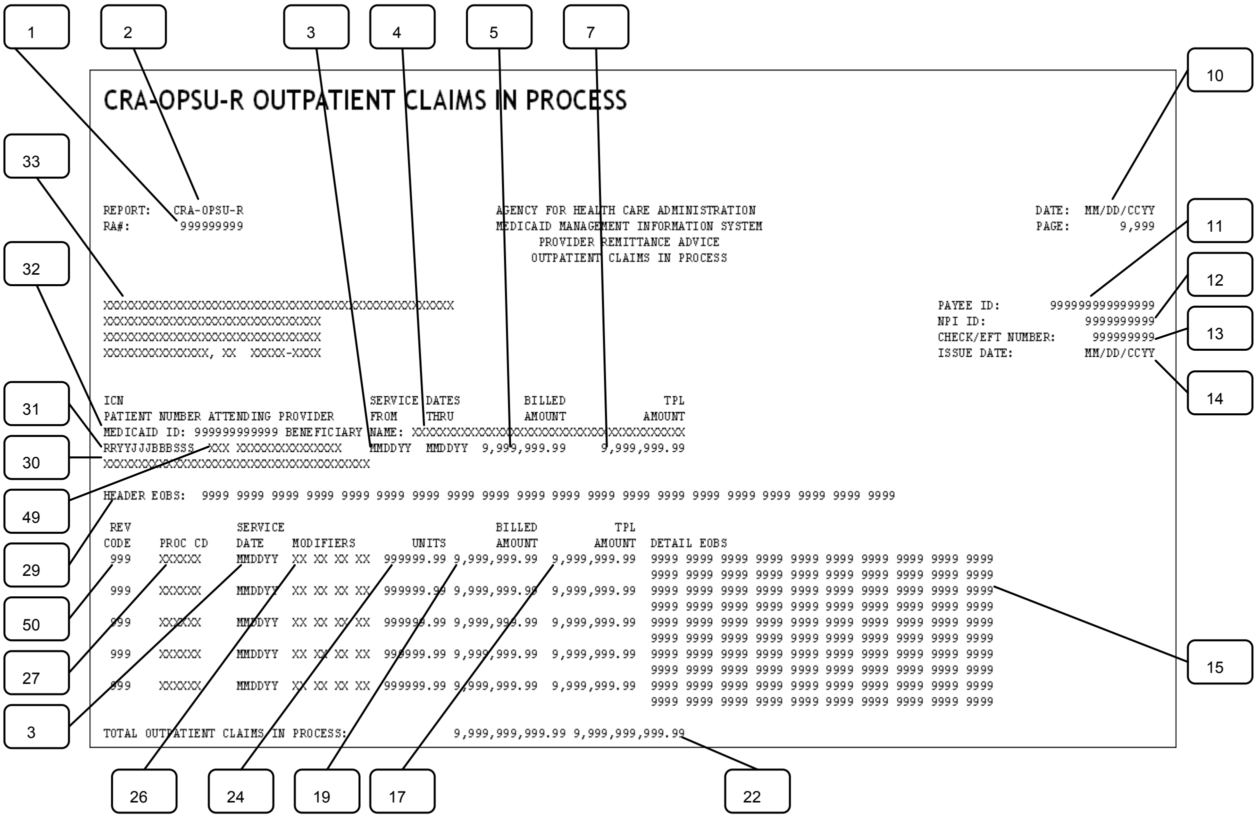


Illustration 2-4. Sample Outpatient Claim Adjustments

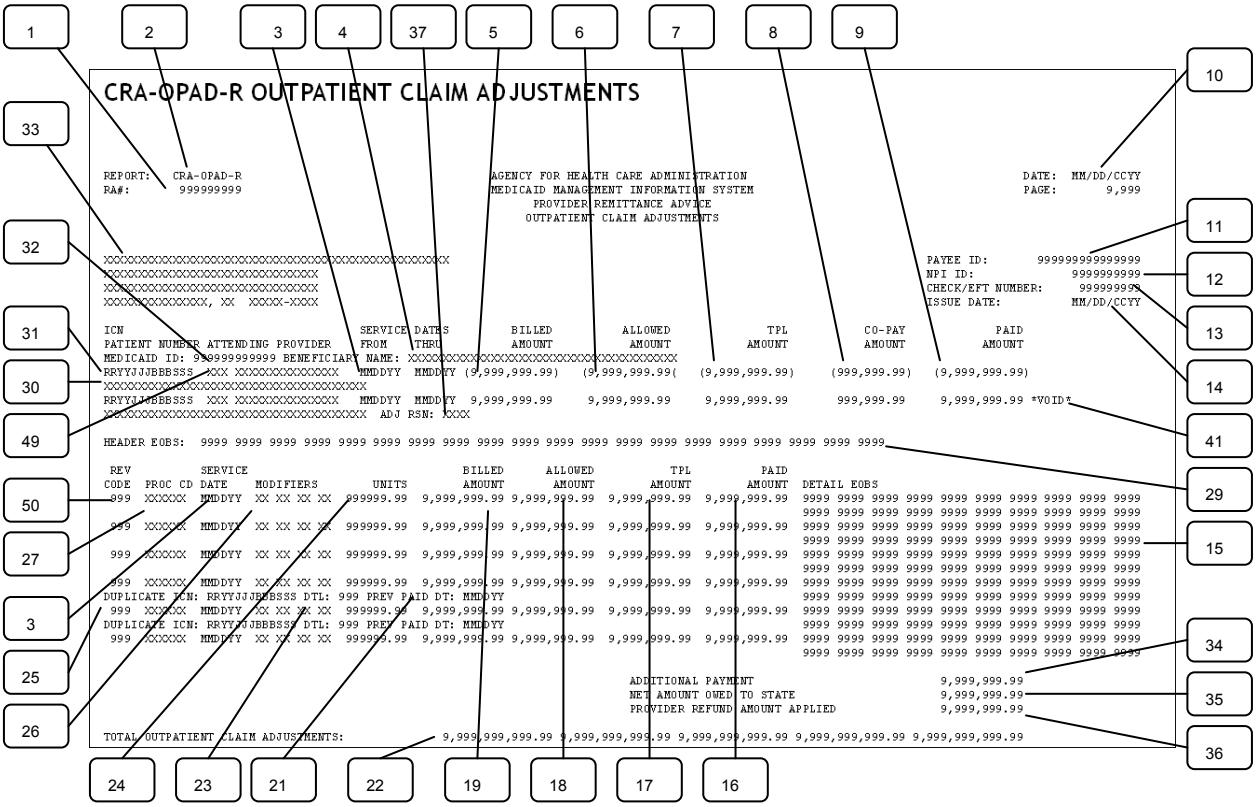
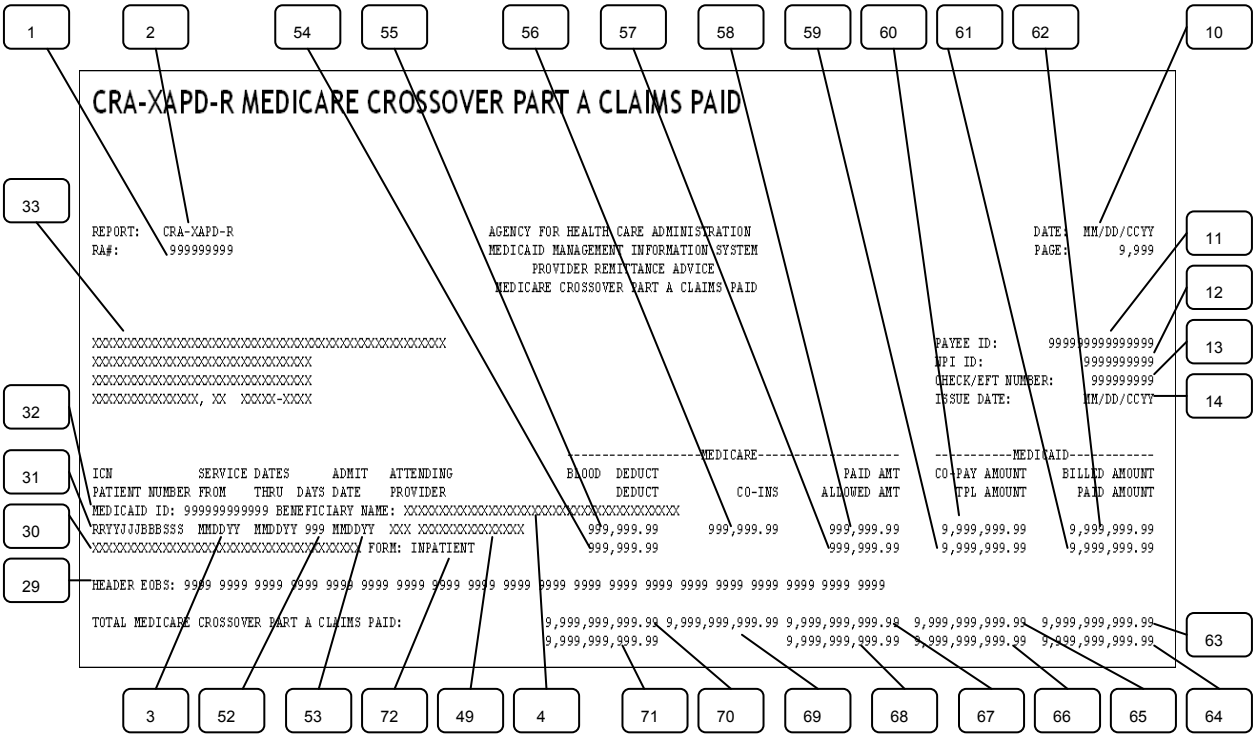


Illustration 2-5. Sample Medicare Crossover Part A Claims Paid



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.

How to Read the Remittance Advice, continued

Field Title ID	FIELD TITLE	FIELD TITLE DESCRIPTION
36	PROVIDER REFUND AMOUNT APPLIED	The refund amount received from the provider and is listed under each applicable ICN.
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 the originally billed claim to the remittance voucher. 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

On an outpatient hospital claim, 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

Form Locator	Title	Action
1	**Provider Name and Address**	If using a new claim form, enter the provider's name and address.
4	**Type of Bill**	Enter the appropriate Type of Bill code in Form Locator 4. Circle the Type of Bill code in black ink. • Inpatient Void 0118 • Outpatient Void 0138 • Critical Care Void 0858 • Freestanding Dialysis Center Void 0728 • Hospice Void 0818 • Skilled Nursing – Inpatient (including Medicare Part A) Voids 0218 • Skilled Nursing – Inpatient (including Medicare Part B) Voids 0228 • Skilled Nursing – Outpatient Voids 0238 • Skilled Nursing Facility (SNF) Level I Voids 0258 • Skilled Nursing Facility (SNF) Level II Voids 0268 • Intermediate Care Facility (ICF) Level I Voids 0658 • Intermediate Care Facility (ICF) Level II Voids 0668
8b	**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 proof of eligibility.

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

Form Locator	Title	Action
56	**NPI**	If using a new claim form, the provider must enter either its NPI in Form Locator 56 or Medicaid provider number in Form Locator 57. If the provider enters its NPI and its NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the provider must enter qualifier code B3 and the taxonomy code in Form Locator 81.
57 A-C	**Other Provider ID**	If using a new claim form, the provider must enter either its NPI in Form Locator 56 or Medicaid provider number in Form Locator 57.
60 A-C	**Insured's Unique ID**	Enter the recipient's Medicaid identification number. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C. If Medicaid is primary, enter the recipient's Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID number in Form Locator 60B.
45 Line 23	**Creation Date**	If using a new claim form, it must be dated. Use the month, day, year format: MMDDYY. Example: 082108 for August 21, 2008.
80	**Remarks**	Enter "FC" followed by the three-digit Financial Classification Code in line 1 Enter the most recently paid Internal Control Number (ICN) for the incorrectly paid claim on line 2. For a legacy claim that the prior Medicaid fiscal agent processed that has a 17-digit Transaction Control Number (TCN), enter the TCN. Note: See Appendix A for the Internal Control Number (ICN) Region Codes.

Illustration 2-6. Sample Void Request--UB-04

1 ABC Hospital
123 Palm Street
Anywhere, FL 33333-1234
(805) 999-8888

2

3a PAT. CNTL # 12345
b MED. REC. #

4 TYPE OF BILL 0138

5 FED. TAX NO. 58-1234567

6 STATEMENT COVERS PERIOD FROM 081108 THROUGH 081108

7

8 PATIENT NAME a
b Resident, Florida A

9 PATIENT ADDRESS a 108 Main St.
b Anywhere c FL d 33333 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
0421972	F	081108		2	7		01													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a 10	081108													a
b														b

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0250	Pharmacy		081108	032	480.00		1
2	0300	Laboratory	87118	081108	001	110.00		2
3	0300	Laboratory	87086	081108	001	8.00		3
4	0370	Anesthesia		081108	001	250.00		4
5	0450	Emergency Room		081108	001	150.00		5
6	0710	Recovery Room		081108	001	200.00		6
7	0790	Lithotripsy	52353	081108	001	700.00		7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16		Hospital Outpatient VOID SAMPLE						16
17								17
18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE	083008	TOTALS	1898.00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567891
A	Florida Medicaid		Y				57	010000100
B							OTHER	
C							PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A	18	7412345922		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	123456700		
B			
C			

66 DX 9: 592.0 Y 250.8 Y

67 A B C D E F G H I J K L M N O P Q

68

69 ADMIT DX 590.0

70 PATIENT REASON DX 590.0

71 PPS CODE

72 ECI

73

74 PRINCIPAL PROCEDURE CODE 790 DATE 081108

a. OTHER PROCEDURE CODE DATE

b. OTHER PROCEDURE CODE DATE

75

c. OTHER PROCEDURE CODE DATE

d. OTHER PROCEDURE CODE DATE

e. OTHER PROCEDURE CODE DATE

80 REMARKS FC 100
10-08188-999-999

81CC a b c d

76 ATTENDING NPI 9076543210 QUAL OB ME9999999
LAST Smith FIRST Jane

77 OPERATING NPI 9876543210 QUAL OB ME1234567
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450
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OMB APPROVAL PENDING

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

How to File an Adjustment Request on a Paper Claim

Requirements for Filing an Adjustment

An adjustment request is processed as a replacement to 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. Adjustments can also be submitted electronically.

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 original payment.

Partially Incorrect Claim Lines on a Claim Form

For an outpatient claim, use the following procedures when some claim lines on a claim form paid correctly and other lines did not pay correctly.

If some claim lines paid correctly and some lines 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 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. 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. If the request is marked as a void, all the claim lines will be recouped.

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 the form 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

Form Locator	Title	Action
1	**Provider Name and Address**	If using a new claim form, enter the provider's name and address.
4	**Type of Bill**	Enter the appropriate Type of Bill code in Form Locator 4. Circle the Type of Bill code in black ink. • Inpatient Adjustment 0117 • Outpatient Adjustment 0137 • Critical Care 0857 • Freestanding Dialysis Center Adjustment 0727 • Hospice Adjustment 0817 • Skilled Nursing – Inpatient (including Medicare Part A) Adjustment 0217 • Skilled Nursing – Inpatient (including Medicare Part B) Adjustment 0227 • Skilled Nursing – Outpatient Adjustment 0237 • Skilled Nursing Facility (SNF) Level I Adjustment 0257 • Skilled Nursing Facility (SNF) Level II Adjustment 0267 • Intermediate Care Facility (ICF) Level I Adjustment 0657 • Intermediate Care Facility (ICF) Level II Adjustment 0667
8b	**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 proof of Medicaid eligibility.

How to File an Adjustment Request on a Paper Claim, continued

Form Locator	Title	Action
23	**Totals**	Enter the adjusted bill amount if it is different from the original billed amount.
56	**NPI**	If using a new claim form, the provider must enter either its NPI in Form Locator 56 or Medicaid provider number in Form Locator 57. If the provider enters its NPI and its NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the provider must enter qualifier code B3 and the taxonomy code in Form Locator 81.
57 A-C	**Other Provider ID**	If using a new claim form, the provider must enter either its NPI in Form Locator 56 or Medicaid provider number in Form Locator 57.
60 A-C	**Insured's Unique ID**	Enter the recipient's Medicaid identification number. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C. If Medicaid is primary, enter the recipient's Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID number in Form Locator 60B.
45 Line 23	**Creation Date**	If using a new claim form, it must be dated. Use the month, day, year format: MMDDYY. Example: 082108 for August 21, 2008.
80	**Remarks**	Enter "FC" followed by the three-digit Financial Classification Code in line 1. Enter the most recently paid Internal Control Number (ICN) for the incorrectly paid claim on line 2. For a legacy claim that the prior Medicaid fiscal agent processed that has a 17-digit Transaction Control Number (TCN), enter the TCN. Be sure the correct type of bill code is entered in Form Locator 4. Note: See Appendix A for the Internal Control Number Region Codes.
	Correcting Errors	Correct any errors or add missing information that caused the incorrect payment, e.g., wrong number of units, incorrect billed amount, or wrong procedure code. Circle the corrected or added information in black ink. a. If the error was because the Medicaid 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 in the Paid By Primary Carrier column on adjustment requests. c. For outpatient adjustments related to third party payment amounts, ensure that the total of the line items in Form Locator 48 equals the third party amount in Form Locator 54. Circle all changes in black ink.

Illustration 2-7. Sample Adjustment Request--UB-04

1 ABC Hospital
123 Palm Street
Anywhere, FL 33333-1234
(805) 999-8888

3a PAT. CNTL # 23
b. MED. REC. #
4 TYPE OF BILL 0117
5 FED. TAX NO. 58-1234567
6 STATEMENT COVERS PERIOD FROM 070108 THROUGH 070408

8 PATIENT NAME b Resident, Florida A
9 PATIENT ADDRESS a 108 Main St. b Anywhere c FL d 33333

10 BIRTHDATE 04291972 | 11 SEX F | ADMISSION 12 DATE 070108 | 13 HR 10 | 14 TYPE 2 | 15 SRC 7 | 16 DHR 19 | 17 STAT 01 | CONDITION CODES 18 C1

31 OCCURRENCE CODE 10 DATE 070108

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0121	Semi-Private Room			~~002~~ 003	2200.00 ~~1400.00~~	
0170	Nursery			~~002~~ 003	1350.00 ~~900.00~~	
0250	Pharmacy			032	480.00	
0300	Laboratory			009	300.00	
0360	Operating Room Services			001	800.00	
0370	Anesthesia			001	250.00	
0450	Emergency Room			001	150.00	
0720	Labor/Delivery Room			001	175.00	
	Hospital Inpatient ADJUSTMENT SAMPLE					
					5705.00	
0001	PAGE 1 OF 1	CREATION DATE	083008	TOTALS	~~4455.00~~	

50 PAYER NAME A Florida Medicaid | 52 REL. INFO Y | 54 PRIOR PAYMENTS 2455.00
56 NPI 1234567891
57 OTHER PRV ID 010000100

58 INSURED'S NAME A Resident, Florida A | 59 P.REL 18 | 60 INSURED'S UNIQUE ID 7412345922

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX 9 | 67 669.7 Y | 660.1 Y | 662.0 Y
69 ADMIT DX 669.7

74 PRINCIPAL PROCEDURE CODE 74.0 DATE 070108

76 ATTENDING NPI 9076543210 QUAL OB ME7777777 LAST Smith FIRST Jane
77 OPERATING NPI 9876543210 QUAL OB LAST Jones FIRST John

80 REMARKS FC 100
10-08183-999-999

UB-04 CMS-1450 © 2005 NUBC | OMB APPROVAL PENDING | NUBC LIC9213257 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

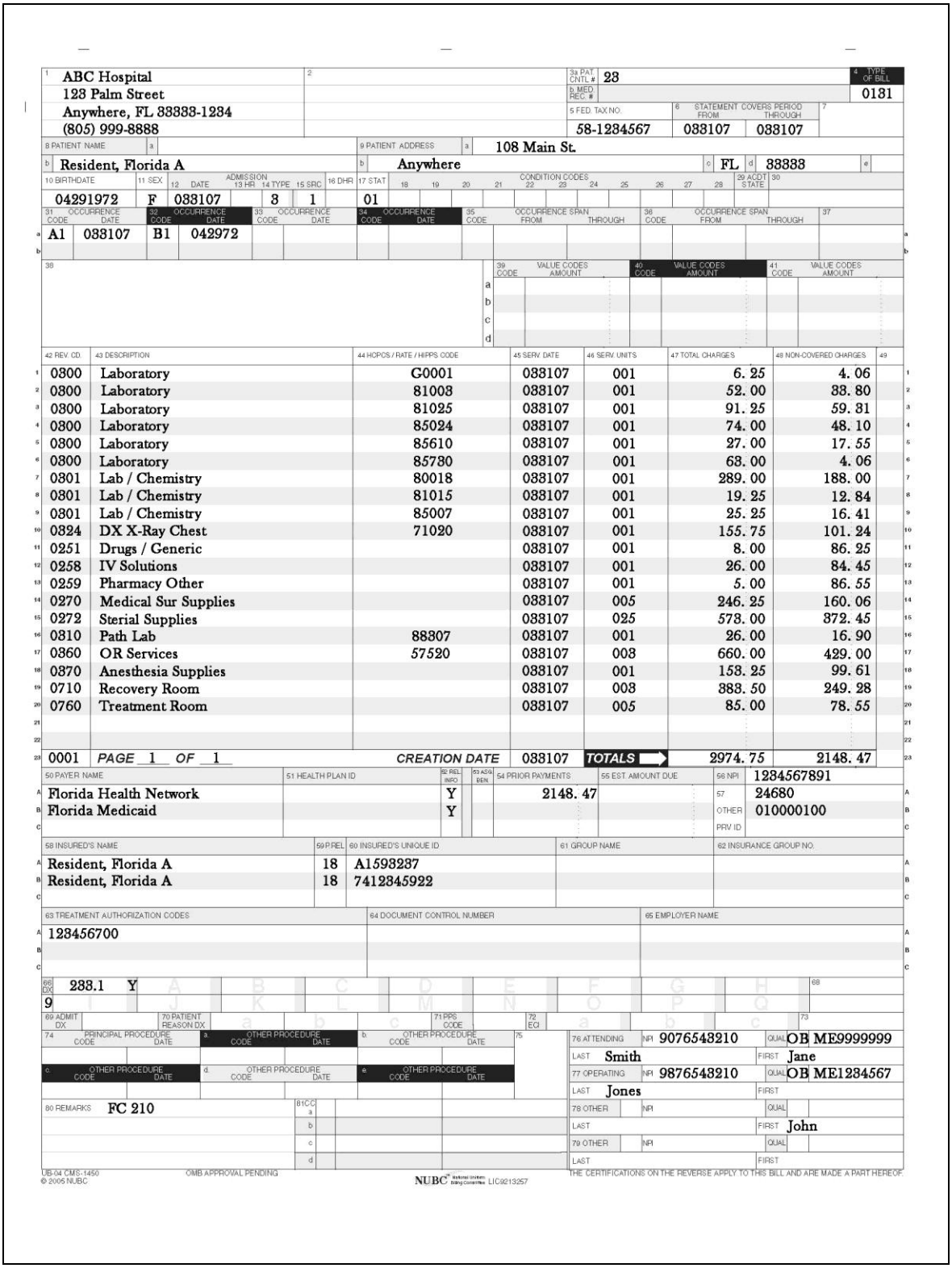
If the discount contract's allowable is less than Medicaid's maximum allowable fee and there remains a patient liability under the plan, use the following procedures to obtain Medicaid reimbursement:

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 Form Locator 54 for inpatient claims or in Form Locator 48 on each claim line item for outpatient claims.

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 an inpatient claim, a prorated outpatient claim, and an EOB for the prorated outpatient claim.

Illustration 2-8. Example of an Inpatient Claim with Contractual Third Party Payment When the Contracted Payment Rate is Less Than the Medicaid Maximum Fee



1 ABC Hospital
123 Palm Street
Anywhere, FL 33333-1234
(805) 999-8888

3a PAT CNTL # 23 | b MED REC # | 4 TYPE OF BILL 0131
5 FED. TAX NO. 58-1234567 | 6 STATEMENT COVERS PERIOD FROM 033107 THROUGH 033107

8 PATIENT NAME: b Resident, Florida A
9 PATIENT ADDRESS: a 108 Main St. | b Anywhere | c FL | d 33333

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE
04291972	F	033107		3	1		01	

	31 OCCURRENCE CODE	31 DATE	32 OCCURRENCE CODE	32 DATE	33 CODE	33 DATE	34 CODE	34 DATE	35 CODE	35 SPAN FROM	35 SPAN THROUGH	36 CODE	36 SPAN FROM	36 SPAN THROUGH	37
a	A1	033107	B1	042972											
b															

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300	Laboratory	G0001	033107	001	6.25	4.06	
2	0300	Laboratory	81003	033107	001	52.00	33.80	
3	0300	Laboratory	81025	033107	001	91.25	59.31	
4	0300	Laboratory	85024	033107	001	74.00	48.10	
5	0300	Laboratory	85610	033107	001	27.00	17.55	
6	0300	Laboratory	85730	033107	001	63.00	4.06	
7	0301	Lab / Chemistry	80018	033107	001	289.00	188.00	
8	0301	Lab / Chemistry	81015	033107	001	19.25	12.84	
9	0301	Lab / Chemistry	85007	033107	001	25.25	16.41	
10	0324	DX X-Ray Chest	71020	033107	001	155.75	101.24	
11	0251	Drugs / Generic		033107	001	8.00	86.25	
12	0258	IV Solutions		033107	001	26.00	84.45	
13	0259	Pharmacy Other		033107	001	5.00	86.55	
14	0270	Medical Sur Supplies		033107	005	246.25	160.06	
15	0272	Sterial Supplies		033107	025	573.00	372.45	
16	0310	Path Lab	88307	033107	001	26.00	16.90	
17	0360	OR Services	57520	033107	003	660.00	429.00	
18	0370	Anesthesia Supplies		033107	001	153.25	99.61	
19	0710	Recovery Room		033107	003	383.50	249.28	
20	0760	Treatment Room		033107	005	85.00	78.55	
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	033107	TOTALS	2974.75	2148.47	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567891
A	Florida Health Network		Y		2148.47		57	24680
B	Florida Medicaid		Y				OTHER	010000100
C							PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A	18	A1593237		
B	Resident, Florida A	18	7412345922		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	123456700		
B			
C			

66 DX: 9 — 283.1 Y — 67 A B C D E F G H I J K L M N O P Q — 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

80 REMARKS: FC 210

81CC a b c d

76 ATTENDING NPI 9076543210 QUAL OB ME9999999
LAST Smith FIRST Jane
77 OPERATING NPI 9876543210 QUAL OB ME1234567
LAST Jones FIRST
78 OTHER NPI QUAL
LAST FIRST John
79 OTHER NPI QUAL
LAST FIRST

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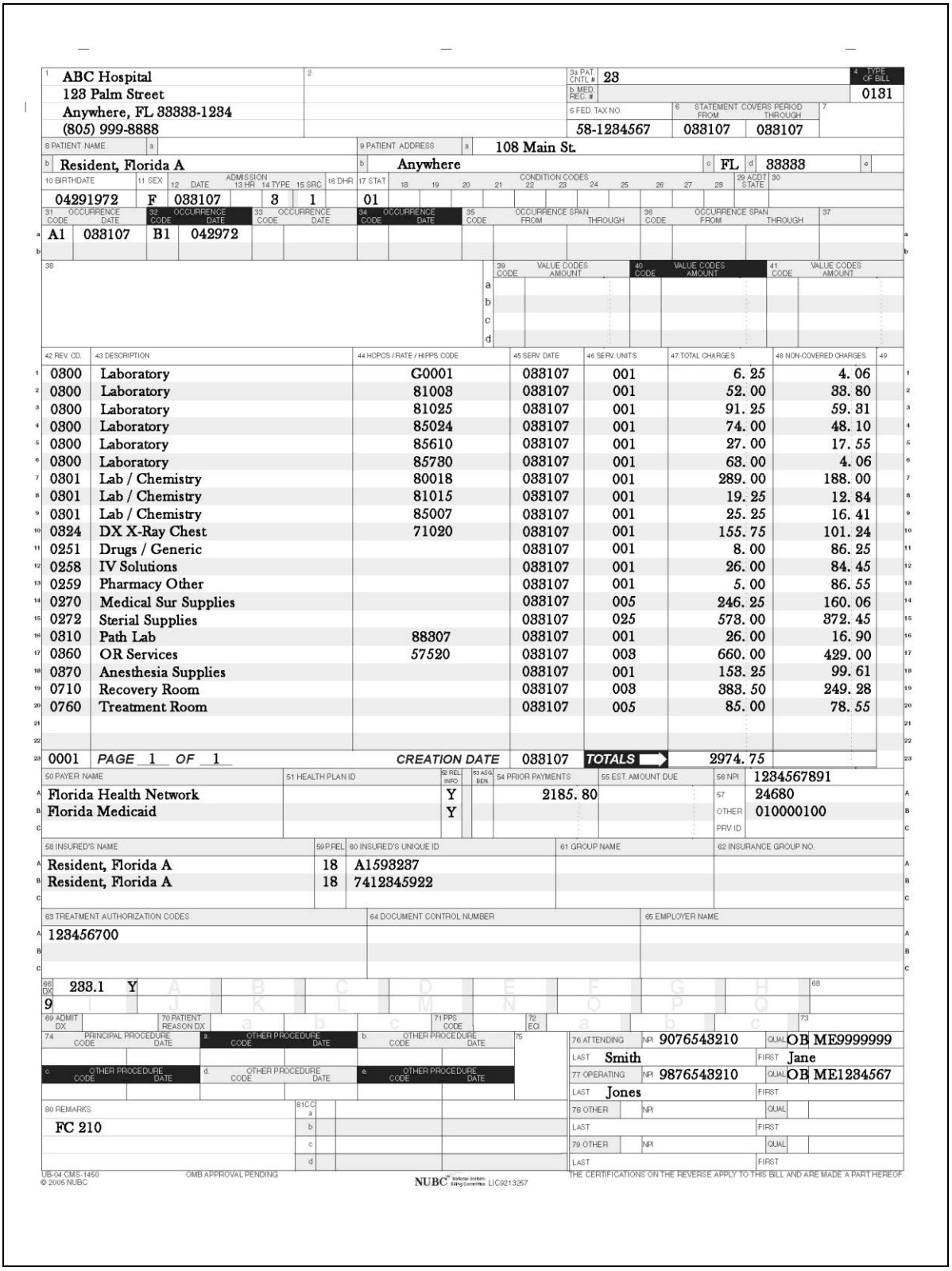
Illustration 2-9. Example of a Prorated Outpatient Claim with Contractual Third Party Payment When the Contracted Payment Rate is Less Than the Medicaid Maximum



1 ABC Hospital
123 Palm Street
Anywhere, FL 33333-1234
(805) 999-8888

3a PAT. CNTL. # 23
b. MED. REC. #
4 TYPE OF BILL 0131
5 FED. TAX NO. 58-1234567
6 STATEMENT COVERS PERIOD FROM 033107 THROUGH 033107

8 PATIENT NAME: b Resident, Florida A
9 PATIENT ADDRESS: a 108 Main St. b Anywhere c FL d 33333

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
04291972	F	033107		3	1		01

CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a A1	033107	B1	042972											a
b														b

38

39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a					
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300	Laboratory	G0001	033107	001	6.25	4.06	1
2	0300	Laboratory	81003	033107	001	52.00	33.80	2
3	0300	Laboratory	81025	033107	001	91.25	59.31	3
4	0300	Laboratory	85024	033107	001	74.00	48.10	4
5	0300	Laboratory	85610	033107	001	27.00	17.55	5
6	0300	Laboratory	85730	033107	001	63.00	4.06	6
7	0301	Lab / Chemistry	80018	033107	001	289.00	188.00	7
8	0301	Lab / Chemistry	81015	033107	001	19.25	12.84	8
9	0301	Lab / Chemistry	85007	033107	001	25.25	16.41	9
10	0324	DX X-Ray Chest	71020	033107	001	155.75	101.24	10
11	0251	Drugs / Generic		033107	001	8.00	86.25	11
12	0258	IV Solutions		033107	001	26.00	84.45	12
13	0259	Pharmacy Other		033107	001	5.00	86.55	13
14	0270	Medical Sur Supplies		033107	005	246.25	160.06	14
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16	0310	Path Lab	88307	033107	001	26.00	16.90	16
17	0360	OR Services	57520	033107	003	660.00	429.00	17
18	0370	Anesthesia Supplies		033107	001	153.25	99.61	18
19	0710	Recovery Room		033107	003	383.50	249.28	19
20	0760	Treatment Room		033107	005	85.00	78.55	20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE	033107	TOTALS	2974.75		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	Florida Health Network		Y		2185.80		1234567891	A
B	Florida Medicaid		Y				57 24680	B
C							OTHER 010000100	C
							PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A	18	A1593237		A
B	Resident, Florida A	18	7412345922		B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	123456700		A
B			B
C			C

66 DX 9: 288.1 Y — 67 A B C D E F G H I J K L M N O P Q — 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a OTHER PROCEDURE CODE	DATE	b OTHER PROCEDURE CODE	DATE	75
c OTHER PROCEDURE CODE	DATE	d OTHER PROCEDURE CODE	DATE	e OTHER PROCEDURE CODE	DATE	

76 ATTENDING NPI 9076543210 QUAL OB ME9999999
LAST Smith FIRST Jane
77 OPERATING NPI 9876543210 QUAL OB ME1234567
LAST Jones FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS: FC 210

81 CC a b c d

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Illustration 2-10. Example of the EOB for the Prorated Outpatient Claim with Contractual Third Party Payment When the Contracted Payment Rate is Less Than the Medicaid Maximum Fee

EXPLANATION OF BENEFITS

Stanmark
121 TPL Street
Everywhere, FL 99999

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

PARTICIPATING EMPLOYER
YUMY SEAFOODS, INC
GROUP NO. 19191

DATE: 05/16/07

ABC Hospital
444 Payment Street
Anywhere, FL 33333

CHECK DESTINATION	
ABC HOSPITAL	1920.01
	TOTAL 1920.01

DATES OF SERVICE-PROVIDER/SERVICE	AMOUNT CHARGED	AMOUNT INELIGIBLE	DISCOUNT	AMOUNT COVERED	ENCOUNTER FEE	DEDUCTIBLE	COINSURANCE	BENEFIT	CODE
	1	2	3	4=1 2 3	5	6	7	8=4 5 6 7	
3/31—3/31/07: ABC Hospital Hospital Outpatient	2227.61	0.00	0.00	2227.61	0.00	94.27	213.33	1920.01	
3/31—3/31/07: ABC Hospital Hospital Discount	742.54	0.00	742.54	0.00	0.00	0.00	0.00	0.00	CO
TOTALS	2970.15	0.00	742.54	2227.61	0.00	94.27	213.33	1920.01	

OTHER COVERAGE	0.00
ADJUSTMENTS	0.00
AMOUNT OF PAYMENT	1920.01

EXPLANATION OF CODES

MS 2, 6, 6 & 7 MAY BE BILLED TO PATIENT
0 DISCOUNTED RATE NEGOTIATED WITH THE PROVIDER
PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.

CHAPTER 3
ADDITIONAL FILING REQUIREMENTS

Overview

Introduction

This chapter describes prior authorization, out-of-state claims, Medically Needy recipient claims, and special forms.

In This Chapter

This chapter contains:

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. 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.

Medicare Crossovers

Covered Medicare services that crossover to Medicaid require no prior authorization or MediPass authorization.

Approved Requests

An approved authorization is not a guarantee that Medicaid will reimburse the service. 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 in this handbook for information on the time limit for submitting claims.

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. To receive reimbursement, the provider must enter the ten-digit prior authorization number on the UB-04 claim form, in Form Locator 63A if Medicaid is the primary payer, or in 63B if Medicaid is the secondary payer.

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

Denied Requests

If 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 may appeal the decision to the area Medicaid office. The area Medicaid office will forward the request to the Department of Children and Families (DCF), Office of Appeal Hearings. DCF hearing officers conduct appeal hearings for Medicaid recipients for authorization of services.

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 (NPI) 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.

MediPass Authorization Number

A MediPass authorization number is not required on any medical inpatient UB-04 claim form, except on a claim submitted for a child in the Children's Medical Services (CMS) Network. Inpatient admissions for children in the CMS Network must be authorized by the MediPass primary care physician, not by the PRO.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for information on the CMS Network.

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. An authorization from the PRO requires the entry of an authorization number on the UB-04 claim form.

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. This situation is coded with a type of admission "4" in Form Locator 14 on the UB-04, and occurrence code 42 followed by the mother's discharge date in Form Locator 31. 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. An authorization number covering the hospitalization from the day following the mother's discharge date is required on the UB-04 submitted in the newborn's name and Medicaid number.

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. The entry of the prior authorization number on the UB-04 claim form is required for Medicaid payment. The ten-digit authorization number must be entered in Form Locator 63A, B or C depending if Medicaid is the primary, secondary, or tertiary payer.

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

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.

The ten-digit authorization number must be entered on the UB-04 in Form Locator 63A, B or C depending if Medicaid is the primary, secondary, or tertiary payer. See Chapter 1 of this handbook for billing instructions.

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

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 https://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 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.

Prior Authorization for Other 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 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 Out-of-State Claims in this chapter for information on other types of out-of-state claims that do not require prior authorization.

Physician Certification and 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.

Prior Authorization for Other Out-of-State Services, continued

Where to Submit the Request	The physician must send the request and required documentation to: Bureau of Medicaid Services Out-of-State Prior Authorization Unit 2727 Mahan Drive, Mail Stop 20 Tallahassee, Florida 32308
Medicaid Prior Authorization Unit Responsibility	The Medicaid medical consultant will review the out-of-state request and approve or deny it. The decision will 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.

Authorization for Other Out-of-State Services, continued

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.

Prior Authorization Request Form

PA01 Request Form

The PA01 form, Florida Medicaid Authorization Request, 07/08, must be submitted to the Bureau of Medicaid Services when requesting prior authorization for:

- 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.
- Other non-transplant related out-of-state services.

Note: The PA01 form, Florida Medicaid Authorization Request, 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. It is incorporated by reference in 59G-4.001, F.A.C.

Where to Submit the PA01 Request Form

To request authorization, the completed authorization request form must be submitted to the following address:

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

Prior Authorization Request Form, continued

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

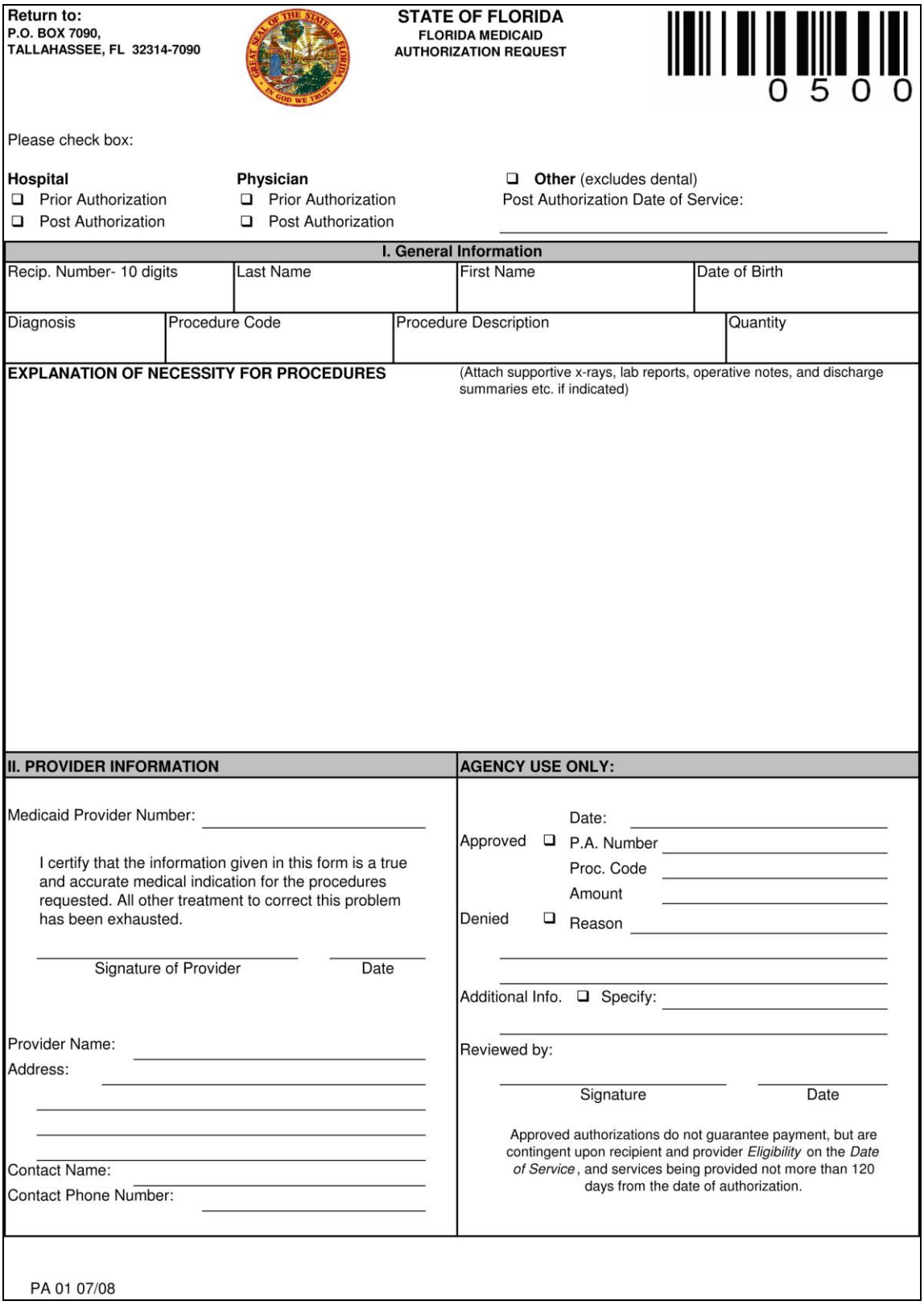
Any items left incomplete on the PA 01 form will result in the form being returned to the requesting provider for completion. The prior authorization request cannot be completed by Medicaid staff or the Medicaid fiscal agent.

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

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

Illustration 3-1. Sample Authorization Request - PA01



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:

Date: _____
Approved ❑ 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. Completed Sample Prior Authorization Request

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	Citizen	Florida	05/04/55

Diagnosis	Procedure Code	Procedure Description	Quantity
Hepatitis C		Liver Transplant	1

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

Based on the assessment during the evaluation, a liver-transplant has been recommended. The physicians have deemed the above patient as a candidate. Clinicals attached.

II. PROVIDER INFORMATION

Medicaid Provider Number: 1234567-00

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 Cure-All MD — Signature of Provider
7/19/08 — Date

Provider Name: John Cure-All, MD
Address: 2151 PineView Drive
Anywhere, FL 32300

Contact Name: John Cure-All, MD
Contact Phone Number: (850) 456-7890

AGENCY USE ONLY:

Date: _____
Approved ☐ 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 Prior Authorization Request Form

Introduction

The purpose of this checklist is to provide instructions for completion of the PA01 form, Florida Medicaid Authorization Request. Providers should check each block to make sure that all items are entered correctly. Proper completion of this form will help avoid unnecessary delays in the processing of the 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.
15. Enter the contact name and phone number.
16. 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.

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 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 eligible for Medicaid is called a "share of cost."

Split Billing and CF-ES 2902 Form

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 2902 Form 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 a CF-ES 2902 Form

When a provider receives a pink copy of a CF-ES 2902 Form, 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 2902 Form, the hospital provider must enter Occurrence Code 73 followed by the date of the recipient's first day of eligibility in Form Locator 31-34 of the UB-04 claim form. No entry in this form locator is required if the service dates are after the first day of eligibility.

Special Billing For Medically Needy Recipients, continued

Instructions for Submitting a CF-ES 2902 Form

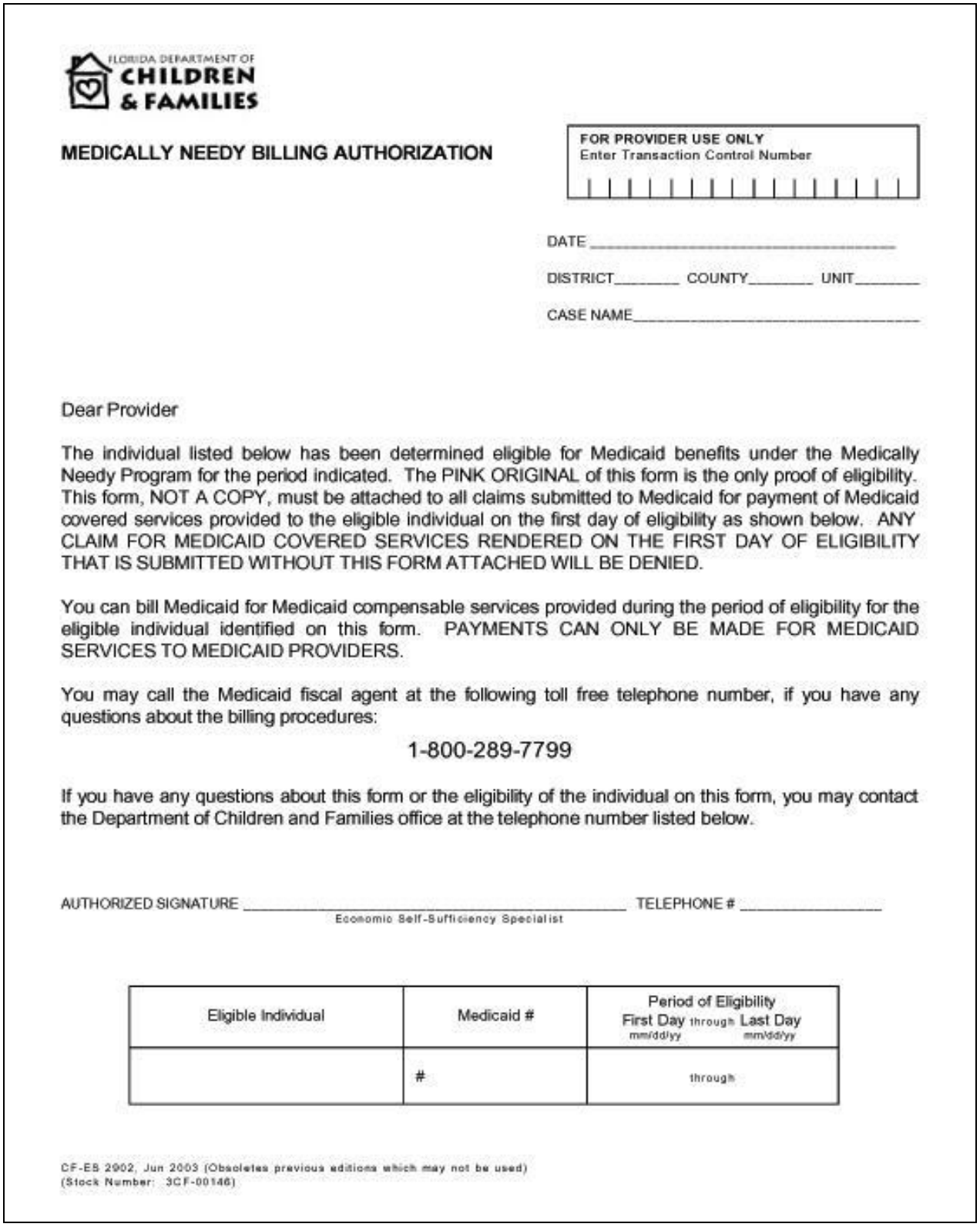
If one or more services were provided on the first day of eligibility, follow the instructions below.

- Enter occurrence code 73 with the first date of eligibility in Form Locators 31-34 on the claim form. Submittal of a hard copy of the CF-ES 2902 Form is not required.
- The provider must keep the pink copy of the CF-ES 2902 Form in the recipient's hospital record.
- If a claim for a Medically Needy recipient must be resubmitted or adjusted, an entry of occurrence code 73 followed by the first date of eligibility on the claim form is sufficient for resubmittal.
- If a photocopy of CF-ES 2902 Form was submitted with the claim form, instead of entering occurrence code 73 to substitute for attachment of the form, the provider must enter the Internal control number (ICN) of the previous claim on the photocopy of the CF-ES 2902 Form, in the box labeled "For Provider Use Only" in the upper right corner of the CF-ES 2902 Form. The photocopy will be rejected if the provider does not enter the previous claim's ICN on the form.

Illustration

A sample of the CF-ES 2902 Form is on the following page.

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

Completing the Form

The following instructions correspond to the preceding illustration.

ITEM	TITLE	WHAT ITEM MEANS
Upper Left	**Provider's Address**	The provider's name and address. If a provider receives a form addressed to another provider, the provider must not use it. The receiving provider must return the form 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**	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 and describing the emergency out-of-state service rendered 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.

Nursing Facility Supplemental Payment for Medically-Fragile Recipients

Introduction	Nursing facilities may receive a supplemental payment for a recipient under 21 who is medically fragile and requires a higher level of skilled care. The nursing facility must have a written recommendation from Children's Medical Services, Children's Multidisciplinary Assessment Team (CMAT), on file prior to the provider billing Medicaid for the supplemental payments. The CMAT recommendation must state the recipient meets the criteria for medically-fragile nursing facility care. Note: See Appendix D, Glossary, in the Florida Medicaid Provider General Handbook for the definition of medically fragile. 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.
Nursing Facility Supplemental Payment Rates	Nursing facility supplemental payment rates for medically-fragile recipients are calculated by Medicaid Program Analysis. To access nursing facility supplemental payment rates, go to AHCA's website at http://ahca.myflorida.com. Click on Medicaid, and then on Cost Reimbursement.
Criteria for the Medically Fragile Supplement	The nursing facility may receive the medically fragile supplemental payment for a recipient under age 21 who has a chronic debilitating disease or condition of one or more physiological or organ systems. The recipient must require an intense level of professional nursing supervision on a continual basis in order to sustain life and prevent irreversible physiological damage. The recipient is usually technology or ventilator dependent. The recipients must be staffed (assessed) by the local Children's Medical Services, Children's Multidisciplinary Assessment Team (CMAT) and receive a written CMAT recommendation that the recipient meets the criteria for medically fragile nursing facility care.
Where to Submit Referrals for Medically Fragile Supplement	Referrals must be submitted to the CMAT to obtain recommendation for medically-fragile nursing facility level of care. Note: See the Children's Medical Services website at http://www.cms-kids.com/CMSNetwork/cmat.html for the CMAT contact information.
How Requests Are Processed	The CMAT conducts a staffing (assessment) to determine if the recipient meets the medically-fragile level of care criteria. The area Medicaid service authorization nurse attends the CMAT staffing and must approve the CMAT's level of care recommendation.

Nursing Facility Supplemental Payment for Medically-Fragile Recipients, continued

Decision Notification	The CMAT documents the medically-fragile level of care in a staffing summary. The CMAT sends copies of staffing summary to the nursing facility, the area Medicaid service authorization nurse, and notifies the recipient's parent or caregiver of the decision.
Medicaid Approved Requests	For medically-fragile recipients, the effective date for Medicaid approval of the supplemental payment is the date that the CMAT established the level of care or the child's admission date to the nursing facility, whichever is later.
Medicaid Denied Requests	If the CMAT staffing (assessment) determines the recipient does not meet the medically-fragile level of care criteria, Medicaid considers the request denied. The CMAT sends a letter to the recipient's parent or caregiver that provides the reason for the denial and information to appeal the decision. The recipient or his legal guardian may appeal the decision to the area Medicaid office. The area Medicaid office will forward the request to the Department of Children and Families (DCF), Office of Appeal Hearings. DCF hearing officers conduct appeal hearings for Medicaid recipients for authorization of services.
Medicaid Eligibility	A Medicaid approved request is not a guarantee that Medicaid will reimburse the supplemental payment. The provider must be enrolled as a Medicaid provider, and the recipient must be eligible on the date of service for Medicaid institutional care services. The provider must submit a clean claim within the time limit for submitting claims. Note: See Chapter 1 for information on the time limit for submitting claims.
Reserved Beds	When a medically fragile recipient goes to the hospital or on a home visit and Medicaid is paying for a reserved bed, the facility is not reimbursed the supplemental payment. If the Medicaid criteria for bed hold payment are met, the facility is reimbursed only the regular Medicaid per diem. The claim must show discharges and readmissions due to supplemental payment changes. Note: Please see the Bed-Hold Reservations and Absences from a Nursing Facility in Chapter 2 of the Florida Medicaid Nursing Facility Coverage and Limitations Handbook. The handbook is incorporated by reference in 59G-4.200, F.A.C.
Submission of a Claim for the Medically Fragile Supplement	For instructions on submitting a claim for the medically-fragile supplement, see Chapter 1

Nursing Facility Supplemental Payment for Recipients with AIDS

Introduction	Nursing facilities may receive a supplemental payment (a dollar amount above the nursing facility per diem rate) for a recipient with AIDS. Payment for residents with AIDS must be prior authorized by Medicaid before Medicaid will pay a facility the AIDS supplemental rate.
Nursing Facility Supplemental Payment Rates	Nursing facility supplemental payment rates for recipients with AIDS are calculated by Medicaid Program Analysis. To access nursing facility supplemental payment rates, go to AHCA's website at http://ahca.myflorida.com. Click on Medicaid, and then on Cost Reimbursement.
Who Submits the Request	Providers requesting prior authorization for the AIDS supplemental payments must be Medicaid certified.
Criteria for the AIDS Supplement	The resident must be approved for the institutional care program (ICP). The AIDS supplemental payment is not available for hospice recipients residing in nursing facilities, residents in the Medicare Part A coinsurance period, or during the period a resident is in the hospital or on home leave. The nursing facility may receive the AIDS supplemental payment for a recipient with a diagnosis of HIV or AIDS for whom the facility has supportive documentation that the recipient is also receiving active treatment for a condition that meets the Centers for Disease Control (CDC) definition of AIDS related illness.
Required Documentation for the AIDS Supplement	The prior authorization request will not be reviewed or approved until all the documentation is received. Prior authorization requests for the AIDS supplemental payment required the submission of the following information: • A letter from the facility requesting the AIDS supplemental payment, including the patient name and the beginning date of service for which the supplemental payment is being requested; • A copy of the admissions cover sheet; • A copy of a positive (the confirming) HIV test (required Western Blot or IFA only); • A copy of the Project AIDS Care Physician Referral and Request for Level of Care Determination, CARES Form 607, revised Aug. 01; • A copy of the patient's current medication sheet;

Nursing Facility Supplemental Payment for Recipients with AIDS, continued

Required Documentation for the AIDS Supplement, continued	• A signed physician letter or statement documenting the AIDS diagnosis and the presence of an AIDS related illness; and • Supportive documentation of active treatment by a physician for a condition that meets the Centers for Disease Control (CDC) definition of an AIDS related illness. Note: The Project AIDS Care Physician Referral and Request for Level of Care Determination, CARES Form 607, revised Aug 01 is available from Department of Elder Affairs, CARES unit. See the Department of Elder Affairs website at http://elderaffairs.state.fl.us/english/cares.html for information on contacting CARES. The form is incorporated by reference in 59G-13.110, F.A.C.
Where to Submit Prior Authorization Requests for the AIDS Supplement	Send the prior authorization request to: Medicaid Services Supplemental Payment Program Prior Authorization 2727 Mahan Drive, Mail Stop 20 Tallahassee, Florida 32308
How Requests Are Processed	Authorization requests are reviewed by Medicaid nursing and medical consultants to ensure medical necessity. Requests are approved or denied in accordance with the above clinical requirements. Medicaid notifies nursing facility providers by letter of the decision to approve or deny the request. If the request is approved, an update to the recipient's file is made in the Florida Medicaid Management Information System (FMMIS) allowing payment of the supplement to proceed. If there is insufficient documentation to make a decision, the letter will identify the additional information that is required. A denial letter will state the reasons(s) for denial of the AIDS supplement.
Submission of a Claim for the AIDS Supplement	For instructions on submitting a claim for the AIDS supplement, see Chapter 1 in this handbook.

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)

PSC 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 3-4.1 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 3-4.1 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 3-5 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 3-6 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.

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 3-7 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 07/2008, 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 3-8. 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)

1

2

3

_____ A. The recipient was already sterile at the time of the hysterectomy.

Specify cause of sterility:

4

_____ Postmenopausal

_____ Congenital disorder: Specify_____

5

_____

_____ Previously surgically sterilized: Specify method

6

_____

_____ 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.

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).

9

_____
(Physician Signature)

10

_____ _____
Fiscal Agent Screening Supervisor (Date)

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 3-9 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).

1

2

X A. The recipient was already sterile at the time of the hysterectomy. 3

Specify cause of sterility: 4

_____ Postmenopausal

_____ Congenital disorder: Specify_____ 5

_____

X Previously surgically sterilized: Specify method 6

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. 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).

9

John Jones, M.D.
(Physician Signature)

10

8/15/08
(Date)

_____
Fiscal Agent Screening Supervisor

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 3-10 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 2-11 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 (localuse)
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?
2.	❑	❑		2.	Have you moved more than 3 times in the last 12 months?
3.	❑	❑		3.	Do you feel unsafe where you live?
4.	❑	❑		4.	Do you or any member of your household go to bed hungry?
5.	❑	❑		5.	In the last 2 months, have you used any form of tobacco?
6.	❑	❑		6.	In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)?
7.	❑	❑		7.	In the last year, has anyone hit you or tried to hurt you?
8.	a❑b❑c❑			8.	How do you rate your current stress level? (a) low, (b) medium, (c) high
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
10.	❑	❑		10.	Have you considered adoption for this pregnancy?
11.	❑	❑		11.	Do you now, or have you ever had, problems with depression?
12.	❑	❑		12.	Do you have a history of receiving mental health counseling?
13.	❑	❑	❑	13.	Is your partner unemployed?

1Y (1)	2Y T (1)	3Y (1)	4Y (1)
5Y (1)	6Y T (1)	7Y T	8C T
9C **T** (1)	10Y T	11Y T	12Y T
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?
15.	❑	❑		15.	Does patient have any illness that requires continuing medical care? Specify illness: _____

14Y (1) 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)

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)_____

2 or 3T **T**

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

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

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