# CMS-1500 Workshop

## Presented by Mina Reynaga Provider Field Representative





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## **ACS Helpdesks**

Call 505-246-0710 or 800-299-7304 - to directly reach all provider help desks including Provider Relations Provider Enrollment, the HIPAA/EMC help desk and TPL.



## **ACS Info**

For all contact, Claims, and Correspondence Addresses information go to the following link on the New Mexico Medicaid Web Portal:

• <u>https://nmmedicaid.acs-</u> <u>inc.com/nm/general/loadstatic.do?page=ContactUs.htm</u>



## **Important State Websites**

## STATE WEBSITE:

## PROGRAM POLICY MANUAL

<u>http://www.hsd.state.nm.us/mad/policymanu</u>
 <u>al.html</u>

## BILLING INSTRUCTIONS

<u>http://www.hsd.state.nm.us/mad/billingins</u>
 <u>tructions.html</u>

## REGISTERS AND SUPPLEMENTS:

http://www.hsd.state.nm.us/mad/registers/



# ACS Field Representatives



Provider Field Representative: Mina Reynaga- (505) 246-9988 Ext. 223; (800) 282-4477 Ext 223

• E-mail: <u>Erminia.Reynaga@acs-inc.com</u>



As of May L<sub>1</sub> Medical Assistance Division policy requires payment to be made only via electronic funds transfer (EFT). As stated in section 8.302.2.9, "MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made." (Please see <u>Program Policy</u> <u>Manual)</u>



### ELECTRONIC FUNDS TRANSFER HUNDREDS OF PROVIDERS HAVE SIGNED UP!

#### PLEASE GO TO TODAY!

#### How to sign up for Electronic Fund Transfer Easy four step process

User Home

#### Step One:

Log in to the New Mexico Medicaid Portal as the Master Administrator. In the Links on the left hand side, click on Email/EFT Administration.

Step Two: Enter your EIN or SSN in the marked box

#### Claim Status

Eligibility

Prior Authorization

Payment History

Change Password

Web Registration Change Provider

NPI Submission Reports & Files Reports & Data Files

Payment History

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User Administratio

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**Claim Status** Prior Authorization

User Home Change Password Web Registration Change Provider

User Administration Email/EFT dministratio

Administration

User Home

Welcome Idiaz99 (Luis Diaz)!

Today is Friday, July 31, 2009, You last signed in on Tuesday, July 14, 2009 at 03:12 PM MST.

Please note that after 15 minutes of inactivity, you will be automatically logged out; however, you will be notified in advance so that you can extend the session. As the inactivity warning is a pop-up window, all pop-up blockers should be disabled for this site only.

#### Email/EFT Administration - Verify EIN/SSN

Before updating EFT account information for your organization, please enter your organization's EIN/SSN for verification.

denotes required field(s)

	* EIN/SSN:	
n	Submit	Clear



Cancel

### Step Three:

You will need to fill in your account type, account number and bank routing transit number. You will also need to provide your Email address. Then select submit. Eligibility Claim Status Prior Authorization Payment History Administration User Home Change Password Web Registration Change Provider User Administration Email/EFT Administration NPI Submission Reports & Files Reports & Data Files

#### Email/EFT Administration - Edit Information

Please make desired changes to EFT account information below. In addition to EFT information, please include a general email address for your provider organization for receipt of notifications from the Medical Assistance Division.

For newly entered EFT account information, the Begin Date will default to the current date. The Begin Date for new information cannot overlap prior EFT information.

If you need to change existing EFT account information, please change the End Date to yesterday's date, and then click the 'Submit' button. The system will then dose the existing EFT account information, and you will be able to enter the new account information.

denotes required field(s)

EFT Accoun	t Inform	ation
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EFT Appro	oval Date:	IVEW		
* Account T	Гуре:	Checking 💌		
* Account N	lumber:	1122233333	* Confirm Account Number:	1122233333
* Routing T Number:	ransit	444455556	Confirm Routing Transit Number:	444455556
Begin Dal General Pr	te: rovider E	07/31/2009 mail Address	End Date:	12/31/9999
* Provider Email:	anyen	nail@host.com	* Confirm Provider Email: anyemai	@host.cam



Q,

**Step four:** Then you will receive a confirmation.

Eligibility Claim Status	Email/EFT Admini	stration - Conf	irmation
Prior Authorization	Thank you		
Payment History			
Administration	Your EFT account inform	ation and/or gene	ral provider email address have been successfully
Uver Home	updated.		
Change Password			
Web Registration	EFT Account Informati	on	
Change Provider			
User Administration	EET Status:	Test	
Email/EFT Administration	EFT Approval Date:	06/10/2009	
NPI Submission	Account Type:	Checking	
Reports & Files	Account Number:		1865
Reports & Data Files	Routing Transit Number	: 112206459	
	Begin Date:	06/10/2009	End Date: 12/31/9999
	General Provider Emai	Address	
	* Provider Email:		
			OK

Submit

Keset

Cancel



## REMINDER! Remittance Advice Update

Registered Web Portal users are no longer mailed an RA. The current RA and newsletter are available on the web portal. The current RA and newsletter are available on the web portal every Monday. along with last & RA's. Please download your RA for future reference



## Purpose of workshop

Provide information on filling out the CMS-1500 paper claims for:

- Primary Medicaid
- Medicaid secondary to a Third Party Liability (TPL)
- HM0/PP0 copayments
- Medicare replacement plans
- Medicare Crossovers
- Medicaid Tertiary



## **Eligibility Check List**

Date of Service - Make sure client is eligible on DOS Is the Client Fee for Service, SALUD!, or CoLTS? Limited Benefits - Check Category of Eligibility TPL, Medicare, Medicare Replacement Plans -There may be a payer primary to Medicaid The client may be required to pay a co-pay



# Ways to Check Eligibility

On-Line Eligibility Inquiry-Web Portal https://nmmedicaid.acs-inc.com/ Automatic Voice Response System (AVRS) (505) 246-2219 or (800) 820-6901



## **Online Eligibility Inquiry**

		neip1 search 1
Inquiries	Org Name: ARROYO CHAMISO PEDIATRIC CENTER	Provider ID: 00046433
Eligibility	Eligibility Inquiry	
Claim Status		
Prior Authorization	Submit '	nquiryna click
Administration	oddinici	
Automistration	*	
Change Password	aenotes requirea tiela(s)	
Web Registration	**	
User Administration	Date of Service:  U/  Ub  2UUb	
Reports & Files	- Client Inquiry	
Reports & Data Files		
	Client ID:	o "SSN stylo" ID
	C Card ID: Located on front of client's	number
	C SSN: Date of Birth:	1
		# 
	C Last Name: Date of B	irth:
	Submit	
	Online Security   Browser Compatibility   Terms of Use   Privacy Policy	/*



## **Online Eligibility Inquiry**

Eligibi	lity Response	a .			
09/13/2	007 12:58 PM N	1DT			4
Date of S Client ID	y Criteria Service: 06/11/2	:007			
Forthel	equested date o	service, your inc	quiry returne	d the following eligib	ility information.
Client In	formation				
Client ID:			Clier	nt Name:	
Date of B	irth:		Sex:	:	
Medicaid	Card ID:		Rec	ertification Date:	
Category	of Engibility Inf	ormation			
COE Code	Benefit I	Description		COE Add Date	Co-Pay
032	Full Med	licald benefits		05/12/2007	
Lock-In	Information				
Lock In T	/pe		Provi	der Name	
BEHAVIOR	AL HITH STATEWIN	DE ENT.	VALU	EOPTIONS OF NM INC, (	csc
Medicare	Information	61 6			
	care information	n on the for the re	equested dat	e of service.	
Third Pa	rty Liability Infor	mation			
No TPL	information on f	ile for the reques	ted date of	service.	
_		-			
Long Ter	m Care Informati	on			
No long	term care inform	nation on file for	the provider	and requested date	of service.
-					
		Modify Crit	teria N	ew inquiry	
					•





## **Claim Form Requirements**

All claims that do not require an attachment for payment must be submitted electronically. Professional claims are submitted on the &37P electronically and the CMS-1500 on paper. MAD requires that all paper CMS-1500 claim forms be on the original red claim forms. Photocopies of claim forms are returned to your billing office.



## **Electronic Claim Submission**

All Fee For Service claims within 90 days from the initial date service that do not require an attachment for payment must be submitted electronically.





## Three Ways to Submit Claims Electronically

Payerpath - Free HIPAA Compliant web-based claims
entry system.

TIE (Transaction Interface Exchange) - the State of NM's HIPAA translator. If you have software that will generate a HIPAA compliant file you can directly submit the file to NM Medicaid via TIE. TIE is another free service.

Through a Clearinghouse



Three Ways to Submit Claims Electronically

The URL to the registration form for PayerPath submissions and the Trading Partner Agreement to submit to TIE is:

http://www.hsd.state.nm.us/mad/hipaa.html





## **CMS-1500 Claim Submission**

The following claim is how a paper CMS-1500 claim form is generally filled out.

You must use procedure codes, etc. that are specific to your claims.



## Where to get a copy of claim form instructions

	INEW MEXICO
devise the Me	clicald Portal
States of the Barbar States of States	A AND A A
Home   Contact Us   FAQ   Provider Information   Unks   HIPAA Information	Help Search
Welcome to the New Mexico Medicaid Portal Click On	<b>Provider Information</b>
The New Mexico Web Portal extends the business capabilities of Medicaid program providers by offering user-friendly tools and resources electronically. Registered users may Log In to access the following interactive features of the portal:	User Login User ID:
Claim Status Inquiry     Prior Authorization Inquiry     Eligibility Inquiry	Password: <u>Provider ID or</u> NPI:
<ul> <li>Payment History Inquiry</li> <li>Reports and Data Files</li> </ul>	Log In I forgot my password
Currently enrolled providers can register for portal access using <u>Web Registration</u> . New providers seeking to join the program can download a <u>Provider Enrollment</u> Packet for step-by-step instructions.	I'm a new user (Web Registration)

For more information about the web portal or New Mexico Medicaid program, turn to the FAQ, What's New (updated: 02/27/2008), Current Remittance Advice Newsletter, or Search functionality.

#### SUBMIT YOUR NPI TO THE NEW MEXICO MEDICAID PROGRAM!

<u>Click here</u> to submit your NPI to the NM Medicaid fee-for-service Medicaid program. If you have rendering providers affiliated with your billing provider number, you can also submit their NPIs using this web site.

Even if your organization is not registered for web portal access, you can still submit your NPI. But while you're here, you could save time and money by registering your organization to use all the features of the web portal! Go to <u>Web</u> <u>Registration</u> to get started.

Remember that NPI is required for all healthcare providers. For more information, please see MAD Supplement 07-08: http://www.hsd.state.nm.us/mad/pdf\_files/Supplements/M\_REG\_S\_07\_08.pdf





## Where to get a copy of claim form instructions

PayerPath		DDE Exment			
	PPT Format	PDF Format			
Web Portal	Not Available	PDF Format			
DME Billing Workshop	Not Available	PDF Format			
EMSA Troubleshooting	PPT Format	PDF Format			
Hospice Billing	Not Available	PDF Format			
FOHC Billing Workshop	PPT Format	PDF Format			
NF and ICF/MR Billing	PPT Format	PDF Format			
PT/OT/SLP Billing	PPT Format	PDF Format			
Transportation Billing	PPT Format	PDF Format			
Waiver Billing Workshop	Not Available	PDF Format		C	1
CLTS Overview	Not Available	PDF Format		Scroll	aown
		Back to Top			
Forms, Publications, and Instructions For more information on HSD program policies, refer to: <u>New</u> <u>Program Policy Manual</u>	Mexico Medical Assista	ance Division			
Adjustments, Voids, and Inquiries The following publications contain detailed instructions for fill Request Form (AVR) and the claim inquiry form.	ling out the Adjustmer	t/Void		<b>O</b> p	en file
Downloading Tips					
Topic	Word	Adobe	_		
Adjustment//oid Request Form and Instructions - 04/08	Word Format	PDE Format			
Claim Inquiry Form - 02/04:	Word Format	PDF Format			
CMS-1500 Professional Claim Form UB-04 Institutional Claim Form	Not Available Not Available Not Available	PDF Format PDF Format			
DA 2006 Deptal Claim Form		E DI LUN I			
ADA 2006 Dental Claim Form	NOT AVAILABLE	Back to Top			
EOB List The following publications contain detailed descriptions of EC	DB Codes and Copaym	Back to Top ent amounts.			
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EOB List The following publications contain detailed descriptions of EC Topic EOB List (6/06)	DB Codes and Copaym Word Word Format	Back to Top ent amounts. Adobe PDF Format			
EOB List The following publications contain detailed descriptions of EC Topic EOB List (6/06) SCHIP and WDI Copayment Amounts (6/06)	DB Codes and Copaym Word Word Format Word Format	Back to Top ent amounts. Adobe PDF Format PDF Format			
ADA 2006 Dental Claim Form EOB List The following publications contain detailed descriptions of EC Topic EOB List (6/06) SCHIP and WDI Copayment Amounts (6/06)	DB Codes and Copaym Word <u>Word Format</u> <u>Word Format</u>	Back to Top ent amounts. Adobe PDF Format PDF Format Back to Top			
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EOB List         The following publications contain detailed descriptions of EC         Topic         EOB List (6/06)         SCHIP and WDI Copayment Amounts (6/06)         View these documents with Microsoft Word, PowerPoint, or , Reader. Adobe Acrobat Reader must be installed on your cor have Acrobat Reader installed, click the icon at right to dowr software.         Online Security   Browser Compatibility   Terms of Use   Privacy Policy Copyright © 2001 - 2008 ACS, Inc. All rights reserved.         Build Version: NM-PROD-5.03 2008.04.21 - 19	DB Codes and Copaym Word Word Format Word Format Adobe Acrobat mputer. If you do not nload this free	Back to Top ent amounts. Adobe PDF Format DDF Format Back to Top GerAdobe Reader			

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## **Medicaid Primary Claim Forms**





### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA			PICA
MEDICARE MEDICAID TRICARE CH (Medicare #) (Medicaid #) (Sponsor's SSN) (M	HAMPVA GROUP FECA fember ID#) (SSN or ID) (SSN) (ID)	1112	23333 (For Program in Item 1)
ATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Las	t Name, First Name, Middle Initial)
Patient, Petunia	11 11 90 M FX		
ATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS	(No., Street)
	Self Spouse Child Other		
1	STATE 8. PATIENT STATUS	CITY	STATE
	Single Married Other		
	e) Employed Full-Time Part-Time	ZIP CODE	()
THER INSURED'S NAME (Last Name, First Name, Middle Initial	I) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY G	ROUP OR FECA NUMBER
			OEV
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CARRIER --



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# **Timely Filing Denials**

<u>Re-filing Claims and Submitting Adjustments</u>

CMS 1500 form: Put the TCN in block 22 on the paper form. Leave the "Code" blank, and put the TCN in the "Original Reference No." field.



## Medicaid Third Party Liability (TPL) Claim Forms



# Third Party Liability (TPL) Tips

TPL is commercial insurance TPL must be billed primary to Medicaid Medicaid does not consider Medicare TPL





#### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA							PICA
1. MEDICARE MEDICAID TRICA				R 1a. INSURED'S I.	NUMBER	(For Program	m in Item 1)
(Medicare #) (Medicaid #) (Sponse	ors SSIV) (Member IL		(SSN) (ID)	A 4	.1225555		
2. PATIENT'S NAME (Last Name, First Name, Mi	ddle Initial)	3. PATIENT'S BIRTH DA	TE SEX	4. INSURED'S NA	ME (Last Name, First N	ame, Middle Initial)	
Patient, Petunia		11 11 90	M F				
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONS Self Spouse	Child Other	7. INSURED'S AD	DRESS (No., Street)		
CITY	STATE	8. PATIENT STATUS Single Marr	ied Other	CITY			STATE
ZIP CODE TELEPHONE	(Include Area Code)			ZIP CODE	TELEP	HONE (Include Area	a Code)
( )		Employed Employed	me Part-Time Student		(	)	
9. OTHER INSURED'S NAME (Last Name, First ) Patient, Petunia	Name, Middle Initial)	10. IS PATIENT'S COND	ITION RELATED TO:	11. INSURED'S PO	OLICY GROUP OR FEC	CA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUM $010203$	MBER	a. EMPLOYMENT? (Curr YES	ent or Previous)	a. INSURED'S DA		SEX	F
b. OTHER INSURED'S DATE OF BIRTH	SEX F	6. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S M	NAME OR SCHOOL NA	ME	
c. EMPLOYER'S NAME OR SCHOOL NAME		a. OTHER ACCIDENT?		c. INSURANCE PL	AN NAME OR PROGR	AM NAME	1
ABC, Inc.		YES	NO				Ĭ
d. INSURANCE PLAN NAME OR PROGRAM NA	ME	10d. RESERVED FOR LO	DCAL USE	d. IS THERE ANO	THER HEALTH BENEF	IT PLAN?	ć
UnitedHealthcare Com	munity Plan			X YES	NO If yes, re	turn to and complete	a item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SI to process this claim. I also request payment of below.	M BEFORE COMPLETING GNATURE I authorize the r government benefits either t	a SIGNING THIS FORM. release of any medical or of to mysen or to the party who	her information necessary b accepts assignment	<ol> <li>INSURED'S OF payment of me services descri</li> </ol>	R AUTHORIZED PERS dical benefits to the uno bed below.	ON'S SIGNATURE I lersigned physician	l authorize or supplier for
SIGNED		DATE		SIGNED			
14. DATE OF CURRENT: MM DD YY INJURY (Accide PREGNANCY(L	ymptom) OR 15. I	F PATIENT HAS HAD SAI	ME OR SIMILAR ILLNESS	. 16. DATES PATIE		TO	
17. NAME OF REFERRING PROVIDER OR OTH	vvnen ti	lling out a	Medicald	a claim	DN DATES RELATED	TO CURRENT SE	RVICES
	where	TPL is pri	mary pay	er, be		то	
	sure to	fill in all re	equired p	rimary			ACS
	and sec	ondary pa	ayer inforr	nation.		A <b>xerox</b>	🔊 Company

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9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?	lano I	\$ C	HARGES
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E     1. L65663     3. L	by Line)	22. MEDICAID RESUL			IEF. NO.
V283		23. PRIOR AUTHORIZ		NDEN	
A. DATE(S) OF SERVICE     From     To     PLACE OF     (Explain Unusual Circum     DD     YY     MM     DD     YY     SERVICE     EMG     CPT/HCPCS	ES, OR SUPPLIES E. Istances) DIAGNOSIS MODIFIER POINTER	F. \$ CHARGES	G. DAYS E OR I UNITS	H. I. PSDT ID. Pan QUAL.	J. RENDERING PROVIDER ID. #
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along with the explanation of denials page	Alwa	ys enter the paid in Box 2	amour 29 on t	he CM	nsurance has S-1500.
along with the explanation of denials page	Alwa	ys enter the paid in Box 2	amour 29 on t	NPI	nsurance has S-1500.
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along with the explanation of denials page	27. ACCEPT ASSIGNMENT?	ys enter the paid in Box 2 28. TOTAL CHARGE \$ 570	amour 29 on t 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	NPI	NID 30. BALANCE DUE 450 0
along with the explanation of denials page	27. ACCEPT ASSIGNMENT? Pror govt. claims, see back VINFORMATION	ys enter the paid in Box 2 28. TOTAL CHARGE \$ 570 33. BILLING PROVIDE Provider Mou	amour 29 on t 29 on t 1234 1 1234 1 1234 1	NPI NPI NPI AMOUNT PA 120 PH II ( Sp ! Rocky View,	ND 30. BALANCE DUE 0 00 \$ 450 00 ) 505 333-4444 Road NM 8888

NUCC Instruction Manual available at: www.nucc.org

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



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## Medicaid HMO/PPO Copayment Claim Forms



# **HMO Co-Pay Tips**

Write "HMO Co-pay Due" on the claim. Attach the EOB.

In the "amount paid" field (Box 29), enter the difference between the billed amount and the co-payment.

Enter the co-payment amount in the "est. amount due" field (Box 30).



1500 HMO CO-PAY DUE HEALTH INSURANCE CLAIM FORM

### Write "HMO Co-pay Due" in the upper left hand side of the claim form next to the "1500" and attach the EOB.

(Medicare #) (Me	edicaid #) (Sponsor's SSN) (N	lember ID#) (SSN or ID) (SSN) (ID)	111223333
2. PATIENT'S NAME (LBS Patient	t Name, First Name, Middle Initial) <b>Petunia</b>	11 11 1990 M	<ol> <li>INSURED'S NAME (Last Name, First Name, Middle Initial)</li> </ol>
PATIENT'S ADDRESS	(No., Street)	6. PATIENT RELATIONSHIP TO INSURED Sell Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
YTIC		STATE 8. PATIENT STATUS Single Married Other	CITY STATE
ZIP CODE	TELEPHONE (Include Area Code	Employed Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code) ()
other insured's NA Patien	AME (Last Name, First Name, Middle Initia <b>t, Petunia</b>	I) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S PO	DLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
MM DD YY		b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
ABC. Inc.	R SCHOOL NAME	a. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
nitedHealth	ME OR PROGRAM NAME care Community P	an 10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
2. PATIENT'S OR AUTH to process this claim. I below.	READ BACK OF FORM BEFORE COMP ORIZED PERSON'S SIGNATURE I author also request payment of government benefit	CETING & SIGNING THIS FORM. rize the release of any medical or other information necessary s either to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED		DATE	SIGNED
4. DATE OF CURRENT:	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	FROM
7. NAME OF REFERRIN	G PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO



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NUCC Instruction Manual available at: www.nucc.org

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



## Medicare Replacement Plan Claim Forms



# Medicare Replacement Plan (MRP) Claim Tips

Write "Medicare Replacement Plan Only" on the claim. Attach the EOB.

In the "amount paid" field (B0X 29), enter the difference between the billed amount and the co-payment.

Enter the co-payment amount in the "est. amount due" field (Box 30).



1500

MEDICARE REPLACEMENT PLAN

Write "Medicare Replacement Plan" in the upper left hand side of the claim form next to the "1500". Attach the EOB.

#### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA				
. MEDICARE MEDICAID TRICARE (Medicare #) (Medicaid #) (Sponsor's SSN)	CHAMPVA GROUP FECA OTHE HEALTH PLAN BLK LUNG (ID) (Kember ID#) (SSN or ID) (SSN) (ID)	1 1a. INSURED'S I.D. NUMBER (For Program in Item 1 1112233333	1)			
PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia	3. PATIENT'S BIRTH DATE SEX 11 11 1990 M FX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)				
YT	STATE 8. PATIENT STATUS Single Married Other	CITY STATE	TE			
ZIP CODE TELEPHONE (Include Area (	Code) Employed Student Student	ZIP CODE TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle I	nitial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY M F	1			
D. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME				
. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME				
J. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	d.			
READ BACK OF FORM BEFORE CO 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 a to process this claim. I also request payment of government be below.	DMPLETING & SIGNING THIS FORM. uthorize the release of any medical or other information necessary nefits either to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier services described below.</li> </ol>	r for			
SIGNED	DATE	SIGNED				
14. DATE OF CURRENT: MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	ų			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO TO	į			



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19. RESERVED FOR LOCAL USE		20. OUTSIDE	LAB? \$0	CHARGES
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	Enter the	o-payment amou	nt in the "net due	e" field
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25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 27. ACCE Optional	PT ASSIGNMENT? 28. TOTAL CI vit. dams, see backi S NO \$	ARGE 29. AMOUNT P 570 00 \$ 120	AID         30. BALANCE DUE           0         00         \$         450         00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCATION INFORMATI	ION 33. BILLING P Provid	er Med Gp (5	05 <sup>)</sup> 333-4444
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Situational	M	1234 Rocky	Road
Required	a	11 22 45		
SIGNED NOCULIE DATE		12345		SLFUUUUX
vocc instruction manual available at, ww	BILLING PR	OVIDER'S NPI	T/	AXONOMY
(IAXONOMY IS NOT RE	QUIRED FOR RENDERI	NG PROVIDER)		

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# Medicare Primary Claim Forms (Crossovers)



## Medicare Primary Claims (Crossovers)

When billing for clients covered by Medicare for which Medicare has paid <u>something</u> on the claim and the claim <u>DID NOT</u> automatically crossover from Medicare to ACS<sub>1</sub> submit those claims via paper to ACS with the Medicare EOMB attached.





#### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA				PICA			
. MEDICARE M (Medicare #) (M	IEDICAID TRICARE CHAM CHAMPUS Iedicaid #) (Sponsor's SSN) (Memb	PVA GROUP FECA OTHER BLK LUNG (SSN or ID) (SSN) (ID)	a Ia. INSURED'S I.D. NUMBER 1112233	(For Program in Item 1) 333			
Patient'S NAME (La Patien	ist Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name,	First Name, Middle Initial)			
5. PATIENT'S ADDRESS	S (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Str	te he TDL se he			
CITY		certain that you do not fil	l in any of the TPL i	nformation blocks.			
ZIP CODE	TELEPHONE (Include Area Code)	Employed Student Student	ZIP CODE	TELEPHONE (Include Area Code)			
9. OTHER INSURED'S N	VAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP C	DR FECA NUMBER			
a. OTHER INSURED'S P	POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX			
D. OTHER INSURED'S D MM DD YY		b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHO				
C. EMPLOYER'S NAME	OR SCHOOL NAME	C. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR P	PROGRAM NAME			
I. INSURANCE PLAN N	AME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
12. PATIENT'S OR AUTH to process this claim. I below.	READ BACK OF FORM BEFORE COMPLET HORIZED PERSON'S SIGNATURE 1 authorize t I also request payment of government benefits eith	ING & SIGNING THIS FORM. he release of any medical or other information necessary her to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED payment of medical benefits to the services described below.</li> </ol>	PERSON'S SIGNATURE I authorize the undersigned physician or supplier for			
SIGNED		DATE	SIGNED				
14. DATE OF CURRENT	T ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	FROM	WORK IN CURRENT OCCUPATION MM DD YY TO			
17. NAME OF REFERRIN	NG PROVIDER OR OTHER SOURCE	17a	18. HOSPITALIZATION DATES RE MM DD YY FROM	LATED TO CURRENT SERVICES MM DD YY TO			



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0. RESERVED FOR LOCAL USE	20, OUTSIDE LAB? \$ CHARGES
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3	23. PRIOR AUTHORIZATION NUMBER
- L 4. L ,	
A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From To PLACEOF (Explain Unusual Circumstances) DIAGNOSI: M DD YY MM DD YY SERVICE EMG CPT/HCPCS   MODIFIER POINTER	S F. G. H. I. J. DAYS EPSDT ID. RENDERING OR Family UNITS Pan QUAL. PROVIDER ID. #
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of denials page	key this info directly from the EOMB.
along with the explanation of denials page	key this info directly from the EOMB.
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along with the explanation of denials page	And Solary and Solary for the EOMB.         NPI         28. TOTAL CHARGE       29. AMOUNT PAID       30. BALANCE DU
along with the explanation of denials page	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DU \$
Along with the explanation of denials page	28. TOTAL CHARGE 28. TOTAL CHARGE 25. BILLING PROVIDER INFO & PH # ( Provider Med Gp 505 333-4444 1234 Rocky Road Mountain View, NM 8888

NUCC Instruction Manual available at: www.nucc.org

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



## Medicaid Tertiary Claim Forms



## **Medicaid Tertiary Claims**

Medicaid tertiary claims are submitted in the following order:

- Medicare primary
- TPL secondary
- Medicaid tertiary





### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA			PICA			
1. MEDICARE MEDICAID TRICARE CHAM (Medicare #) (Medicaid #) (Sponsor's SSN) (Memb	PVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (ID)	1a. INSURED'S I.D. NUMBER (For Prog 1112233333	ram in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initia	d)			
5. PATIENT'S ADDRESS (No., Street) Fill out the TPL information	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)				
	E 8. PATIENT STATUS Single Married Other	CITY	STATE			
ZIP CODE TELEPHONE (Include Area Code)	Employed Student Student	ZIP CODE TELEPHONE (Include A	rea Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER 010203	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM   DD   YY M F				
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	te) b. EMPLOYER'S NAME OR SCHOOL NAME				
C. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME				
d Insurance plan name or program name	10d. RESERVED FOR LOCAL USE	IS THERE ANOTHER HEALTH BENEFIT PLAN?				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize t to process this claim. I also request payment of government benefits eit below.	A SIGNING THIS FORM. he release of any medical or other information necessary her to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATUR payment of medical benefits to the undersigned physicia services described below.</li> </ol>	E I authorize in or supplier for			
SIGNED	DATE	SIGNED				
14. DATE OF CURRENT: MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT O MM DD YY FROM TO				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a	18. HOSPITALIZATION DATES RELATED TO CURRENT S MM DD YY FROM TO	SERVICES			



CARRIER

A **Xerox**  Company

19. RESE	RVED F	OR LOCAL	. USE								20. OUTSIDE LAB?	NO		\$ CH	ARGES
21. DIAGN	NOSIS O	RNATURE	E OF ILL	VESS OF	r injur	Y (Relate	Items 1, 2, 3 or 4 t	to Item 24	E by Line)	<u> </u>	22. MEDICAID RESUL	MISSION	N ODIC		5 NO
1. L <b>7</b>	213						Fill out o	claim	form as	if you were	e billing seco	ndar	y to	a TP	Ľ.
2. [							4. [								11/
24. A. F MM D	DATE( form DD Y	S) OF SER	To To DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES (Explain Unu: CPT/HCPCS	S, SERVIC sual Circu	CES, OR SUPPLI Imstances) MODIFIER	ES E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
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25. FEDE	Pal TAX	ci.d. NUM Dnal	BER	SSN		26. P	ortient's accou	INT NO,	27. ACCEP For govt	T ASSIGNMENT?	\$ 2589	00	9. AMO	UNT PAIL	00 \$ 1949 00
31. SIGN/ INCLU (I certi apply )	ATURE C UDING D ify that th to this bil	DF PHYSIC EGREES C the statement I and are m	CIAN OR CORED The CRED The on the made a pa	SUPPLIE ENTIAL reverse ut thereo	ER S of.)	32. S	ERVICE FACILITY	atio		IN	33. BILLING PROVIDE Provider M 12	ed G 234 F	8 PH # P Rock	( 50! cy Ro	) 5 333-4444 bad
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NUCC Instruction Manual available at: www.nucc.org

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



## Did you remember to?

Ensure the line item charges are correct and match the total charge.

If you're a for profit organization, make sure gross receipts tax is included in the line items, if applicable.

Procedure and diagnosis codes are entered correctly Sign and date the claim.



## Did you remember to?

Include your NPI or provider number.

Include all appropriate E0B's for TPL, HM0, Medicare, etc.

Attach proof of timely filing/TCN if needed.

Keep a copy of the correspondence for your records.





