

USER GUIDE

Medicaid Illinois Professional User Guide



**Document
Version 1.0**



Copyright

Contents of the Emdeon documentation and software is copyrighted as a collective work under the laws of United States and other copyright laws.

Claim Master[®] is a trademark of Emdeon Business Services. Emdeon holds the copyright in the collective work.

Microsoft[®] and Windows[®] are either registered trademarks or trademarks of Microsoft Corporation in the United States and/or other countries.

Adobe[®] and Adobe[®] Reader[®] are either registered trademarks or trademarks of Adobe Systems Incorporated in the United States and/or other countries.

© 2010 Emdeon LLC. All rights are reserved. Only current Emdeon clients can reproduce these materials for internal use. Any other redistribution, retransmission, or publication of any copyrighted material is strictly prohibited without the express written consent of the copyright owner.

CPT Copyright Notice

CPT only © 2010 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.



Table of Contents

Introduction	3
Medicaid Illinois - HFS Forms	4
HIPAA Compliance	4
About This Book	6
Hyperlinks	6
List of Screens	6
List of Tables	6
Usage Restrictions	7
Chapter 1 Completing Claim Master Screens	9
HFS Form 1443	15
HFS Form 2209	25
HFS Form 2210	36
HFS Form 2360	47
HFS Form 2292	57
Chapter 2 Hand-Keying Medicaid Illinois HFS Claims	63
Hand Keying a Medicaid Illinois HFS Claim	64
Chapter 3 Creating and Printing Medicaid Illinois HFS Forms	69
On Demand Claim Forms	69
On Demand Adjustment Forms	71
Submitting Paper Claims	72



Introduction

The *Medicaid Illinois Professional User Guide* contains detailed information about the Emdeon's Medicaid Illinois product.

Medicaid Illinois - HFS Forms

Medicaid Illinois, Healthcare and Family Services (HFS), requires a proprietary form be completed when billing in a hardcopy or paper format and when filing adjustments. The Medicaid Illinois HFS claim forms are specific to the type of service performed and contain data elements unique to Medicaid Illinois HFS. The Medicaid Illinois HFS adjustment form is used for Professional adjustments to Medicaid Illinois HFS.



Client Setup Required

Access to the Medicaid Illinois HFS form specific fields and the capability to create the Medicaid Illinois HFS forms is a premium service that requires setup by the Emdeon Implementation Administrator.

The Claim Master claim form screens have been modified to accommodate the data elements specific to the following Medicaid Illinois HFS forms:

HFS Form Descriptions

Number	Description
1443	Provider Invoice (Therapy)
2209	Transportation Invoice
2210	Medical Equipment/Medical Supplies
2360	Health Insurance Claim Form (Professional)
2292	Adjustment (NIPS)

Color-coded visual aids in this chapter identify the fields on the Claim Master claim form screens that:

Highlighted in yellow	Corresponds to the Medicaid Illinois HFS form
Highlighted in green	Required for billing a Medicaid Illinois HFS claim from Claim Master
Highlighted in yellow	Required for filing an adjustment to Medicaid Illinois HFS from Claim Master

HIPAA Compliance

In order to be Health Insurance Portability Assurance Act (HIPAA) compliant, this version of Medicaid Illinois is based on the current HIPAA-compliant EDI ASC X12 835 data set for Healthcare Electronic Remittance Advice (ERA). While the software contains many data elements of the old HCFA 1500 health claim, the newer CMS 1500- and HIPAA-compliant data elements have been added to provide total compliance.



Note

In order for Medicaid Illinois to function properly, healthcare data must be received from your system in the proper HIPAA-compliant file format or in an 'enhanced' non-HIPAA print image file with supplemental data added to the print image. For additional information, please contact the Emdeon Support Desk at 877-271-0054.

About This Book

Hyperlinks

To improve your ability to navigate between topics (especially related topics), this book incorporates numerous **cross-reference** hyperlinks that display in a blue typeface. These hyperlinks make it easy for you to reference related tables, topics, or other information from the currently displayed page. To move to the related topic, simply click on the blue text.

Each topic in the Table of Contents is also a hyperlink. To move to a chapter, section, or topic in the book from the Table of Contents, click on its title.

Additionally, each chapter in this book has its own Table of Contents on the first page the chapter. **Each section or topic** in each chapter-level Table of Contents is a hyperlink. To move to a section or topic within the chapter, click on its title.

The Bookmarks feature of Adobe® Acrobat Reader or Adobe® Reader® can also be used to move quickly to a chapter, section, or topic. When you have this book open in Acrobat Reader, you can click on the Options pull-down in the Bookmarks window to open the Table of Contents bookmarks. To expand or collapse the level of detail in the Table of Contents, click on the + or – symbols. To move to a chapter, section, or topic in the book, click on a bookmark icon or a title.

List of Screens

All of the Denial Manager graphical user interface displays are referred to as **screens** throughout this book. To facilitate your use of this book as a product reference after you have become familiar with the product, a List of Screens has been provided. This list is located at the back of the book. Each screen name in the List of Screen Images is a hyperlink that you can click to navigate directly to the screen example in the book.

List of Tables

A List of Tables has been provided to provide quick access to the detailed information contained in the tables throughout this book. This list is located at the back of the book. Each table name in the List of Tables is a hyperlink that you can click to navigate directly to the associated table in the book.

Usage Restrictions

When you see an “exclamation” icon or a “padlock” icon in this book, it indicates the description or instructions refer to a product function or usage privileges that are controlled by either the Emdeon Implementation Administrator or the Client System Administrator.

The **Emdeon Implementation Administrator** provides customized product configuration and setup services at your site. Usually, these services are provided at the time of product installation. To provide optimal security for sensitive processes, many Denial Manager functions and their associated usage rights can be controlled only by the Emdeon Implementation Administrator. Some of the functions controlled by this person may require the purchase of product add-ons or a separate Emdeon product.

The **Client System Administrator** is a designated person at your site who can grant or deny user rights to perform actions on certain software features or functions. The Client System Administrator will use the *Denial Manager Administrator Guide* as a reference for performing these tasks.

Both of these people use the product's Setup/Configuration Menu option to control or define product functions and user Privileges. This menu option will display on the Denial Manager Main Menu for these two individuals, and for other users that have been granted related rights.



If you have questions about product functions that are signified as “restricted” by the either the “exclamation” icon or the “padlock” icon, see your Client System Administrator.

Completing Claim Master Screens

The Claim Master claim form screens contain data elements that correspond to the NUCC Professional healthcare claim form, the ANSI 837-P electronic format and the Medicaid Illinois HFS proprietary forms.

For detailed descriptions of the Claim Master claim form screens, see Chapter 2, 837 Professional Claim Form Screens in the *Claim Master Professional User Reference*.

The data elements specific to the Medicaid Illinois HFS claim forms are located on the following Claim Master screens:

- Patient & Subscriber > Patient and Current Subscriber/Payer
- Service Lines > Original Lines
- Service Lines > Adjustment
- Other Info > Ambulance

Screen 1 Patient & Subscriber > Patient and Current Subscriber/Payer Screen (Medicaid IL Fields)

Main Menu -> Create New Claim | Wed Dec 08 21:34:24 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | Validate | Save | Exit

Patient and Current Subscriber/Payer | Other Subscribers/Payers... | Functions | Printing

25. Provider Tax ID: THE DOCTOR'S OFFICE (460447693) Save As: NEW

26. Patient Account Freq Type 12. Release Info Date

2. Patient Name Last First MI 3. BirthDate Sex SSN

5. Address City St Zip Country

Phone 8. Status Marital Employment Student Medical Record Num

10. Related Cause Accident State Country Date Hour

Patient Homebound APG 10d. Local Use DeathDate Accident/Injury

Condition Codes Patient Signature Source

Current Payer MEDICAID IL (HEALTH FAMILY) (D0062100) 1. Subscriber ID 13. Assign Benefit

Provider ID/NPI 1234567893 / 331L00000X 4. Subscriber Name Last First MI

Payer Address 7. Subscriber Address

City State Zip Country City St Zip Country

Insurance Type Original Reference Phone 6. Patient Relationship

23. Prior Auth Referral 11a. BirthDate Sex SSN

Filing Ind 11c. Payer Name MEDICAID IL (HEALTH FAMILY) 11. Grp Name Nbr b. Emp/Sch

Payer Secondary ID Qual ID Health Record Num Patient ID

27. Accept Assignment Par Agmt 31. Signature

32. Facility ID 33. ID ID Taxonomy 331L00000X

Pay-To Provider - SAME AS BILLING PROVIDER -

Table 1 Patient & Subscriber > Patient and Current Subscriber/Payer Screen Field Descriptions (Medicaid IL Fields)

Field	Description												
Accident/Injury	Codes to indicate the probable reason the participant sought treatment for an accident/injury: <div data-bbox="574 1486 1338 1814"> <p>Accident/Injury Code</p> <p>Close</p> <table> <thead> <tr> <th>Code</th><th>Definitions</th></tr> </thead> <tbody> <tr> <td>1</td><td>Employment related accident or illness.</td></tr> <tr> <td>2</td><td>Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle.</td></tr> <tr> <td>3</td><td>Injury due to participation in an organized sport or school activity.</td></tr> <tr> <td>4</td><td>Injury due to an act of violence (non-accidental).</td></tr> <tr> <td>5</td><td>Injury is the result of an unspecified accident.</td></tr> </tbody> </table> </div>	Code	Definitions	1	Employment related accident or illness.	2	Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle.	3	Injury due to participation in an organized sport or school activity.	4	Injury due to an act of violence (non-accidental).	5	Injury is the result of an unspecified accident.
Code	Definitions												
1	Employment related accident or illness.												
2	Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle.												
3	Injury due to participation in an organized sport or school activity.												
4	Injury due to an act of violence (non-accidental).												
5	Injury is the result of an unspecified accident.												

Screen 2 Service Lines > Original Lines Screen (Medicaid IL Fields)

Main Menu -> Create New Claim Fri Jun 11 12:17:26 CDT 2010

Provider: RURAL HEALTH CLINIC (436999977) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: , Patient Control #: TEST MEDICAID IL Claim #:
 From/Thru: Lines: 0 Total Chg: \$0.00 Est Amt Due: \$0.00

Patient & Subscriber **Service Lines** Other Info Edit/Log **Validate** **Save** **Exit**

Original Lines | Adjustment Functions Printing

14. Current Illness Date 15. First Illness Date

Patient Pregnant? ☐ Last Menstrual Date

17. Referring Doctor

Attending Doctor

Supervising Doctor

19. Local Use

Note Reference Code

21. Diagnosis 1. 2. 3. 4.

5. 6. 7. 8.

9. A. B. C.

16. Unable to Work From Thru

Last Work Date Return to Work Date

18. Hospitalization From Thru

Care Assumed Date Relinquished Date

20. Outside Lab? ☐ Charges Steri? ☐

22. Medicaid Resubmission Code Ref

CLIA Num Mammo Cert

EPSDT Referral? ☐ Condition Codes

Special Program Code Demo Proj. Id

Delay Reason Code IDE Number

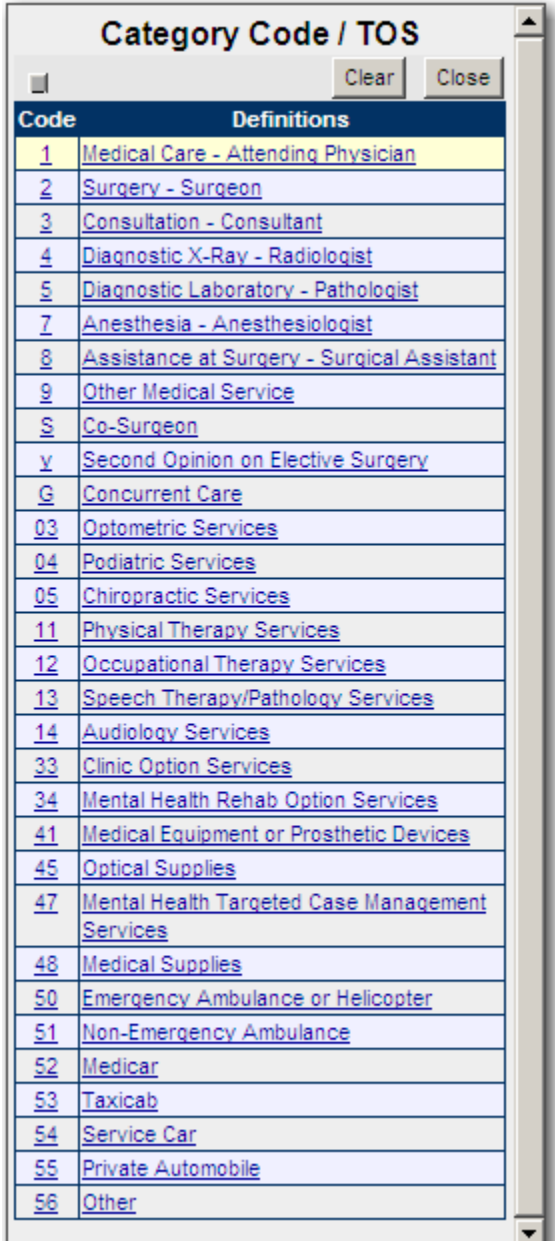
Anesthesia Related Procedure Code

	A. Date of Service		B	C	D. Procedures					E	F	G	H		J	Set	
	From	To			POS	TOS	EMG	HCPCS	M1				M2	M3			M4
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Patient Paid: Total Purchased: 28. Total Charge: 0.00 29. Amount Paid: 30. Balance Due: 0.00

TOTAL PAGES: 1 PAGE LIST: 1 [NEW PAGE/LAST PAGE](#) [Delete Line](#) ☒ Copy ☐ Split [Action](#)

Table 2 Service Lines > Original Lines Screen Field Descriptions (Medicaid IL Fields)

Field	Description																																																																
Steri?	Service submitted for payment for a sterilization or abortion: Y = Yes N = No																																																																
TOS	<p>A one- or two-digit code to identify the Category Code or Type of Service.</p>  <table border="1"> <thead> <tr> <th>Code</th><th>Definitions</th></tr> </thead> <tbody> <tr><td>1</td><td>Medical Care - Attending Physician</td></tr> <tr><td>2</td><td>Surgery - Surgeon</td></tr> <tr><td>3</td><td>Consultation - Consultant</td></tr> <tr><td>4</td><td>Diagnostic X-Ray - Radiologist</td></tr> <tr><td>5</td><td>Diagnostic Laboratory - Pathologist</td></tr> <tr><td>7</td><td>Anesthesia - Anesthesiologist</td></tr> <tr><td>8</td><td>Assistance at Surgery - Surgical Assistant</td></tr> <tr><td>9</td><td>Other Medical Service</td></tr> <tr><td>S</td><td>Co-Surgeon</td></tr> <tr><td>V</td><td>Second Opinion on Elective Surgery</td></tr> <tr><td>G</td><td>Concurrent Care</td></tr> <tr><td>03</td><td>Optometric Services</td></tr> <tr><td>04</td><td>Podiatric Services</td></tr> <tr><td>05</td><td>Chiropractic Services</td></tr> <tr><td>11</td><td>Physical Therapy Services</td></tr> <tr><td>12</td><td>Occupational Therapy Services</td></tr> <tr><td>13</td><td>Speech Therapy/Pathology Services</td></tr> <tr><td>14</td><td>Audiology Services</td></tr> <tr><td>33</td><td>Clinic Option Services</td></tr> <tr><td>34</td><td>Mental Health Rehab Option Services</td></tr> <tr><td>41</td><td>Medical Equipment or Prosthetic Devices</td></tr> <tr><td>45</td><td>Optical Supplies</td></tr> <tr><td>47</td><td>Mental Health Targeted Case Management Services</td></tr> <tr><td>48</td><td>Medical Supplies</td></tr> <tr><td>50</td><td>Emergency Ambulance or Helicopter</td></tr> <tr><td>51</td><td>Non-Emergency Ambulance</td></tr> <tr><td>52</td><td>Medicar</td></tr> <tr><td>53</td><td>Taxicab</td></tr> <tr><td>54</td><td>Service Car</td></tr> <tr><td>55</td><td>Private Automobile</td></tr> <tr><td>56</td><td>Other</td></tr> </tbody> </table>	Code	Definitions	1	Medical Care - Attending Physician	2	Surgery - Surgeon	3	Consultation - Consultant	4	Diagnostic X-Ray - Radiologist	5	Diagnostic Laboratory - Pathologist	7	Anesthesia - Anesthesiologist	8	Assistance at Surgery - Surgical Assistant	9	Other Medical Service	S	Co-Surgeon	V	Second Opinion on Elective Surgery	G	Concurrent Care	03	Optometric Services	04	Podiatric Services	05	Chiropractic Services	11	Physical Therapy Services	12	Occupational Therapy Services	13	Speech Therapy/Pathology Services	14	Audiology Services	33	Clinic Option Services	34	Mental Health Rehab Option Services	41	Medical Equipment or Prosthetic Devices	45	Optical Supplies	47	Mental Health Targeted Case Management Services	48	Medical Supplies	50	Emergency Ambulance or Helicopter	51	Non-Emergency Ambulance	52	Medicar	53	Taxicab	54	Service Car	55	Private Automobile	56	Other
Code	Definitions																																																																
1	Medical Care - Attending Physician																																																																
2	Surgery - Surgeon																																																																
3	Consultation - Consultant																																																																
4	Diagnostic X-Ray - Radiologist																																																																
5	Diagnostic Laboratory - Pathologist																																																																
7	Anesthesia - Anesthesiologist																																																																
8	Assistance at Surgery - Surgical Assistant																																																																
9	Other Medical Service																																																																
S	Co-Surgeon																																																																
V	Second Opinion on Elective Surgery																																																																
G	Concurrent Care																																																																
03	Optometric Services																																																																
04	Podiatric Services																																																																
05	Chiropractic Services																																																																
11	Physical Therapy Services																																																																
12	Occupational Therapy Services																																																																
13	Speech Therapy/Pathology Services																																																																
14	Audiology Services																																																																
33	Clinic Option Services																																																																
34	Mental Health Rehab Option Services																																																																
41	Medical Equipment or Prosthetic Devices																																																																
45	Optical Supplies																																																																
47	Mental Health Targeted Case Management Services																																																																
48	Medical Supplies																																																																
50	Emergency Ambulance or Helicopter																																																																
51	Non-Emergency Ambulance																																																																
52	Medicar																																																																
53	Taxicab																																																																
54	Service Car																																																																
55	Private Automobile																																																																
56	Other																																																																

Screen 3 Service Lines > Adjustment Screen (Medicaid IL Fields)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 12:24:15 CDT 2010

Provider: QAE MEMORIAL HOSPITAL (436999977) Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: Incomplete
 Patient: Patient Control #: TEST426017 0001 Claim #: 7957271
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed [View All Edits](#) << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber **Service Lines** Other Info Edit/Log **Validate** **Save** **Exit**

Original Lines | Adjustment Functions Printing

	DOS From	DOS To	POS	TOS	HCPCS	M1	M2	M3	M4	Charge	Unit	Approved	OTAF
1	20070516	20070516	22		77080					68.80	1 UN		

HFS Adjustment --- [Print Overlay](#) [Print Image](#)

6. Voucher 7. Document Control Number 14. Adj Type 15. Item or Service
 20. Reason Adjustment Requested: 16. Quantity 17. Charges 18. TPL 19. TPL Amt

1.1 Adjudication Payer -- PLEASE SELECT A PAYER -- Add Clear Adjudication Date Paid Amount
 HCPCS M1 M2 M3 M4 Paid Units Bundled Line # Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

28. Total Charge: 68.80 29. Amount Paid: 30. Balance Due: 68.80

Screen 4 Other Info > Ambulance Screen (Medicaid IL Fields)

Main Menu -> Create New Claim | Wed Dec 08 21:35:43 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
Patient: Patient Control #: Claim #:
From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | **Other Info** | Edit/Log | **Validate** | **Save** | **Exit**

General | **Ambulance** | DME | PT/Chiro | Functions | Printing

Claim Ambulance Transport Info:

Patient Weight Lbs Transport Code Reason Code Distance Miles
Round Trip Purpose Stretcher Purpose
Vehicle License Number Vehicle License State

Claim Ambulance Certification

<input type="text"/> 01 Patient was admitted to a hospital	<input type="text"/> 02 Patient was bed confined before the ambulance service
<input type="text"/> 03 Patient was bed confined after the ambulance service	<input type="text"/> 04 Patient was moved by stretcher
<input type="text"/> 05 Patient was unconscious or in shock	<input type="text"/> 06 Patient was transported in an emergency situation
<input type="text"/> 07 Patient had to be physically restrained	<input type="text"/> 08 Patient has visible hemorrhaging
<input type="text"/> 09 Ambulance service was medically necessary	<input type="text"/> 12 Patient is confined to a bed or chair
<input type="text"/> 60 Transportation was to the nearest facility	

Claim Ambulance Location Info:

Pick-Up Address City State Zip Country
Drop-Off Address City State Zip Country
Location

☐ Service Line Ambulance Transport Info/Certification

HFS Form 1443

The HFS 1443 claim form is used to submit claims for Therapy services in a hardcopy or paper format to Medicaid IL. The following Type of Service (TOS) entered on the **Service Lines > Original Info** screen identifies the claim as a HFS 1443 claim form in Claim Master.

- 03 = Optometric Services
- 04 = Podiatric Services
- 05 = Chiropractic Services
- 11 = Physical Therapy Services
- 12 = Occupational Therapy Services
- 13 = Speech Therapy/Pathology Services
- 14 = Audiology Services
- 33 = Clinic Option Services
- 34 = Mental Health Rehab Option Services
- 45 = Optical Supplies
- 47 = Mental Health Targeted Case Management Services

Color-coded visual aids in this chapter identify the fields on the Claim Master claim form screens that:

Highlighted in yellow	Corresponds to the Medicaid Illinois HFS form
Highlighted in green	Required for billing a Medicaid Illinois HFS claim from Claim Master

The Medicaid Illinois HFS form specific data elements listed below were not added to the Claim Master claim form screens as the Payer requires the field to be blank upon submission.

HFS 1443 FL#	HFS 1443 Field Description
4	Role (Leave blank)
23-8	Modifying Units (Leave blank)
24	Optical Materials Only (Leave blank)
33	Sect (Leave blank)
34	Bill Type (Leave blank)

Patient & Subscriber > Patient and Current Subscriber/Payer Screen

Screen 5 Patient & Subscriber > Patient and Current Subscriber/Payer Screen (HFS 1443 Crosswalk)

Main Menu -> Create New Claim | Wed Dec 08 21:34:24 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | **Validate** | **Save** | **Exit**

Patient and Current Subscriber/Payer | Other Subscribers/Payers... | Functions | Printing

25. Provider Tax ID: [] Save As: NEW

26. Patient Account [] Freq Type [] 12. Release Info [] Date []

2. Patient Name Last [] First [] MI [] 3. BirthDate [] Sex [] SSN []

5. Address [] City [] St [] Zip [] Country []

Phone [] 8. Status Marital [] Employment [] Student [] Medical Record Num []

10. Related Cause [] Accident State [] Country [] Date [] Hour []

Patient Homebound [] APG [] 10d. Local Use [] DeathDate [] Accident/Injury []

Condition Codes [] Patient Signature Source []

Current Payer MEDICAID IL (HEALTH FAMILY) (D0062100)

Provider ID/NPI []

Payer Address []

City [] State [] Zip [] Country []

Insurance Type [] Original Reference []

23. Prior Auth [] Referral []

Filing Ind [] 11c. Payer Name []

Payer Secondary ID Qual [] ID []

1. Subscriber ID [] 13. Assign Benefit []

4. Subscriber Name Last [] First [] MI []

7. Subscriber Address []

City [] St [] Zip [] Country []

Phone [] 6. Patient Relationship []

11a. BirthDate [] Sex [] SSN []

11. Grp Name [] Nbr [] b. Emp/Sch []

Health Record Num [] Patient ID []

27. Accept Assignment [] Par Agmt [] 31. Signature []

32. Facility [] ID [] 33. ID [] Taxonomy []

Pay-To Provider []

Table 3 Patient & Subscriber > Patient and Current Subscriber/Payer Screen Field Descriptions (HFS 1443 Crosswalk) (part 1 of 2)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
1	Provider Name	33-2	Provider Tax ID (Name)
2	Provider Number	33a	Provider ID/NPI
3	Payee	N/A	Pay-To Provider (Display Provider)
6	Prior Approval	23	Prior Authorization Number

**Table 3 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 1443 Crosswalk) (part 2 of 2)**

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
7	Provider Street	33-3	Provider ID/NPI (Address - Display Provider)
8	Facility & City Where Service Rendered	32-1	Facility (Name - Search Facility)
8	Facility & City Where Service Rendered	32-3	Facility (City, State, Zip - Search Facility)
9	Provider City, State, Zip	33-4	Provider ID/NPI (City, State, Zip - Display Provider)
11	Recipient Name (First MI Last)	2	Patient Name Last, First, MI
12	Recipient Number	1a	Subscriber ID
13	Birthdate	3-1	Birth Date
19	Taxonomy	33b	Provider ID/NPI
20	Provider Reference	26	Patient Account
32	Original DCN	22-2	Original Reference
36	Provider Signature (Leave blank)	31-1	Signature
37	Date (Leave blank)	31-2	Date
N/A	N/A	Top 1	Payer
N/A	N/A	3-2	Sex
N/A	N/A	4	Subscriber Name Last, First MI
N/A	N/A	5-1	Address
N/A	N/A	5-2	City
N/A	N/A	5-3	State
N/A	N/A	5-4	Zip
N/A	N/A	6	Pat-Ins Relation
N/A	N/A	7-1	Subscriber Address
N/A	N/A	7-2	City
N/A	N/A	7-3	State
N/A	N/A	7-4	Zip
N/A	N/A	11c	Payer
N/A	N/A	12	Release Info - Date
N/A	N/A	13	Assign Benefit
N/A	N/A	27	Accept Assignment
N/A	N/A	N/A	Freq Type

Patient & Subscriber > Other Subscribers/Payers Screen

Screen 6 Patient & Subscriber > Other Subscribers / Payers Screen (HFS 1443 Crosswalk)

Main Menu -> Create New Claim | Wed Oct 27 11:46:41 CDT 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: , Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | **Validate** | **Save** | **Exit**

Patient and Current Subscriber/Payer | **Other Subscribers/Payers...** | Functions | Printing

Other Payer 1 [Dropdown] [Icon]

Provider ID/NPI --PLEASE SET PAYER FIRST--

Payer Address [Text] [Text]

City [Text] State [Text] Zip [Text] - [Text] Country [Text]

Insurance Type [Text] Original Reference [Text]

23. Prior Auth [Text] Referral [Text]

9d. Payer Name [Text] MediGap Id [Text]

Filing Ind [Text] Payer Ref ID Qual [Text] ID [Text] Health Record Num [Text] Patient ID [Text]

9. Subscriber ID [Text] [Icon] 13. Assign Benefit [Text]

9. Subscriber Name Last [Text] First [Text] MI [Text]

Subscriber Address [Text] [Text]

City [Text] St [Text] Zip [Text] - [Text] Country [Text] - [Text]

Phone [Text] Patient Relationship [Text]

9b. BirthDate [Text] Sex [Text] SSN [Text]

9a. Grp Name [Text] Nbr [Text] c.Emp/Sch [Text]

COB/Adjudication Payer Status [New] [Clear] Adjudication Date [Text] Paid Amount [Text] Total Non-Cov [Text]

Approved [Text] Allowed [Text] Covered [Text] Patient Resp [Text] Patient Paid [Text]

Discount [Text] Per Day Limit [Text] Tax [Text] Pre-Tax [Text] OTAF [Text] Patient Liab [Text]

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1	[Text]	[Text]	[Text]	2	[Text]	[Text]	[Text]	3	[Text]	[Text]	[Text]

Other Payer 2 [Dropdown] [Icon]

Provider ID/NPI --PLEASE SET PAYER FIRST--

Payer Address [Text] [Text]

City [Text] State [Text] Zip [Text] - [Text] Country [Text]

Insurance Type [Text] Original Reference [Text]

23. Prior Auth [Text] Referral [Text]

Payer Name [Text] MediGap Id [Text]

Filing Ind [Text] Payer Ref ID Qual [Text] ID [Text] Health Record Num [Text] Patient ID [Text]

Subscriber ID [Text] [Icon] 13. Assign Benefit [Text]

Subscriber Name Last [Text] First [Text] MI [Text]

Subscriber Address [Text] [Text]

City [Text] St [Text] Zip [Text] - [Text] Country [Text] - [Text]

Phone [Text] Patient Relationship [Text]

BirthDate [Text] Sex [Text] SSN [Text]

Grp Name [Text] Nbr [Text] Emp/Sch [Text]

COB/Adjudication Payer Status [New] [Clear] Adjudication Date [Text] Paid Amount [Text] Total Non-Cov [Text]

Approved [Text] Allowed [Text] Covered [Text] Patient Resp [Text] Patient Paid [Text]

Discount [Text] Per Day Limit [Text] Tax [Text] Pre-Tax [Text] OTAF [Text] Patient Liab [Text]

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1	[Text]	[Text]	[Text]	2	[Text]	[Text]	[Text]	3	[Text]	[Text]	[Text]

Table 4 Patient & Subscriber > Other Subscribers/Payers Screen Field Descriptions (HFS 1443 Crosswalk)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
23-9	TPL Code (Line)	N/A	Payer ID (Position 1-3)
23-10	Status (Line)	N/A	Payer ID (Position 4-5)
25A	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
25B	Status (Claim)	N/A	Payer ID (Position 4-5)
25C	TPL Amount (Claim)	N/A	Paid Amount
25D	TPL Date (Claim)	N/A	Adjudication Date
26A	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
26B	Status (Claim)	N/A	Payer ID (Position 4-5)
26C	TPL Amount (Claim)	N/A	Paid Amount
26D	TPL Date (Claim)	N/A	Adjudication Date
27A	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
27B	Status (Claim)	N/A	Payer ID (Position 4-5)
27C	TPL Amount (Claim)	N/A	Paid Amount
27D	TPL Date (Claim)	N/A	Adjudication Date
35	Uncoded TPL Name (Claim)	9d	Payer (Name - Payer ID - Position 1-3 = 999)

Service Lines > Original Lines Screen

Screen 7 Service Lines > Original Lines Screen (HFS 1443 Crosswalk)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 13:12:43 CDT 2010

Provider: [REDACTED] Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: New
 Patient: [REDACTED] Patient Control # [REDACTED] Claim #: [REDACTED]
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed View All Edits << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber Service Lines Other Info Edit/Log Validate Save Exit

Original Lines | Adjustment Functions Printing

14. Current Illness Date [REDACTED] 15. First Illness Date [REDACTED]
 Patient Pregnant? [NO] Last Menstrual Date [REDACTED]
 17. Referring Doctor [REDACTED]
 Attending Doctor Z51288 MONROE, M
 Supervising Doctor [REDACTED]
 19. Local Use [REDACTED]
 Note Reference Code [REDACTED]
 21. Diagnosis 1 [REDACTED] 2 [REDACTED] 3. 73390 4. V7231
 5. [REDACTED] 6. [REDACTED] 7. [REDACTED] 8. [REDACTED]
 9. [REDACTED] A. [REDACTED] B. [REDACTED] C. [REDACTED]
 16. Unable to Work From [REDACTED] Thru [REDACTED]
 Last Work Date [REDACTED] Return to Work Date [REDACTED]
 18. Hospitalization From [REDACTED] Thru [REDACTED]
 Care Assumed Date [REDACTED] Relinquished Date [REDACTED]
 20. Outside Lab? [REDACTED] Charges [REDACTED] Steril. [REDACTED]
 22. Medicaid Resubmission Code [REDACTED] Ref [REDACTED]
 CLIA Num [REDACTED] Mammo Cert [REDACTED]
 EPSDT Referral? [REDACTED] Condition Codes [REDACTED] [REDACTED] [REDACTED]
 Special Program Code [REDACTED] Demo Proj. Id [REDACTED]
 Delay Reason Code [REDACTED] IDE Number [REDACTED]
 Anesthesia Related Procedure Code [REDACTED] [REDACTED]

A. Date of Service	B	C	D. Procedures	E	F	G	H	J
From To POS TOS EMG HCPCS								
05/16/07 05/16/07	22		73390		68.80			
05/16/07 05/16/07								
05/16/07 05/16/07								
05/16/07 05/16/07								
05/16/07 05/16/07								
05/16/07 05/16/07								

Patient Paid: [REDACTED] Total Purchased: [REDACTED] 28. Total Charge [REDACTED] 29. Amount Paid [REDACTED] 30. Balance Due [REDACTED]

TOTAL PAGES: 1 PAGE LIST: 1 NEW PAGE/LAST PAGE Delete Line Copy Split Action

Table 5 Service Lines > Original Lines Screen Field Descriptions (HFS 1443 Crosswalk) (part 1 of 3)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
5	Emer (Leave blank)	24C	EMG
10	Referring Practitioner Name	17	Referring Doctor (Name - Search Doctor)
14	H. Kids (Leave blank)	24H Upper	EPSDT

Table 5 Service Lines > Original Lines Screen Field Descriptions (HFS 1443 Crosswalk) (part 2 of 3)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
15	Fam Plan (Leave blank)	24H Lower	Plan
16	St/Ab (Leave blank)	N/A	Steri?
17	Primary Diagnosis Description	N/A	Diagnosis (Search Diagnosis)
18	Primary Diag Code	21-1	Diagnosis
21	Ref Prac No NPI	17b	Referring Doctor (NPI - Search Doctor)
22	Secondary Diag Code	21-2	Diagnosis
23-1	Procedure Description	N/A	HCPCS (Search HCPCS)
23-2	Proc. Code/NDC	24D-1	HCPCS
23-3	Modifiers	24D-2	M1, M2, M3, M4
23-4	Date of Service	24A Lower	Date of Service - From/To
23-5	Cat Serv <u>Allowed values</u> 03 = Optometric Services 04 = Podiatric Services 05 = Chiropractic Services 11 = Physical Therapy Services 12 = Occupational Therapy Services 13 = Speech Therapy/Pathology Services 14 = Audiology Services 33 = Clinic Option Services 34 = Mental Health Rehab Option Services 45 = Optical Supplies 47 = Mental Health Targeted Case Management Services	N/A	TOS (Value entered determines HFS Form created)
23-6	Place of Serv <u>Allowed values</u> 11 = Office 12 = Home 13 = Assisted Living Facility 14 = Group Home 21 = Inpatient Hospital 22 = Outpatient Hospital 31 = Skilled Nursing Facility 32 = Nursing Facility 33 = Custodial Care Facility	24B	POS
23-7	Units / Quantity	24G	Unit
23-13	Provider Charges	24F	Charge
25	Sect# (Line Number)	N/A	Calculated field
25C	TPL Amount (Patient Paid)	N/A	Patient Paid

Table 5 Service Lines > Original Lines Screen Field Descriptions (HFS 1443 Crosswalk) (part 3 of 3)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
25D	TPL Date (Patient Paid Date)	N/A	Date of Service - From
26	Sect# (Line Number)	N/A	Calculated field
26C	TPL Amount (Patient Paid)	N/A	Patient Paid
26D	TPL Date (Patient Paid Date)	N/A	Date of Service - From
27	Sect# (Line Number)	N/A	Calculated field
27C	TPL Amount (Patient Paid)	N/A	Patient Paid
27D	TPL Date (Patient Paid Date)	N/A	Date of Service - From
28	Tot Charge	28	Total Charge
29	Tot Deductions	29	Amount Paid
30	Net Charges	30	Balance Due
31	# Sect (Number of Lines)	N/A	Calculated field
N/A	N/A	24E	Pntr

Service Lines > Adjustment Screen

Screen 8 Service Lines > Adjustment Screen (HFS 1443 Crosswalk)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 12:24:15 CDT 2010

Provider: _____ Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: Incomplete
 Patient: _____ Patient Control #: _____ Claim #: _____
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed [View All Edits](#) << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber | **Service Lines** | Other Info | Edit/Log | [Validate](#) | [Save](#) | [Exit](#)

Original Lines | Adjustment | Functions | Printing

DOS From	DOS To	POS	TOS	HCPCS	M1	M2	M3	M4	Charge	Unit	Approved	OTAF
1	20070516	20070516	22	77080					68.80	1 UN		

HFS Adjustment --- [Print Overlay](#) [Print Image](#)

6. Voucher 7. Document Control Number 14. Adj Type 15. Item or Service
 20. Reason Adjustment Requested: 16. Quantity 17. Charges 18. TPL 19. TPL Amt

1. Adjudication Payer -- PLEASE SELECT A PAYER -- Adjudication Date Paid Amount
 HCPCS M1 M2 M3 M4 Paid Units Bundled Line # Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

28. Total Charge: 68.80 29. Amount Paid: 30. Balance Due: 68.80

Table 6 Service Lines > Adjustment Screen Field Descriptions (HFS 1443 Crosswalk)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
23-11	TPL Amount (Line)	N/A	Paid Amount
23-12	TPL Date (Line)	N/A	Adjudication Date
25C	TPL Amount (Line)	N/A	Paid Amount
25D	TPL Date (Line)	N/A	Adjudication Date
26C	TPL Amount (Line)	N/A	Paid Amount
26D	TPL Date (Line)	N/A	Adjudication Date
27C	TPL Amount (Line)	N/A	Paid Amount
27D	TPL Date (Line)	N/A	Adjudication Date

Other Info > General Screen

Screen 9 Other Info > General Screen (HFS 1443 Crosswalk)

Main Menu -> Search Claim -> Edit Claim Tue Sep 21 14:20:59 CDT 2010

Provide: XXXXXXXXXX Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: New
 Patient: LAST, FIRST P Patient Control #: XXXXXXXXXX Claim #: XXXXXXXXXX
 From/Thru: 06/06/10 - 06/06/10 Lines: 5 Total Chg: \$100.00 Est Amt Due: \$100.00

Patient & Subscriber | Service Lines | **Other Info** | Edit/Log Validate Save Exit

General | Ambulance | DME | PT/Chiro Functions Printing

Claim Additional Info

Last Seen Date Hearing/Vision Rx Date Newborn Weight Grams Care Plan Oversight
 Referral Number Authorization Exception Code Property & Casualty Claim Num

Claim Contract Info

Type Amount Percent Code Discount Percent Version

Claim Patient Vision Condition Info

1. Category Indicator Condition Code

Claim Paper Work/Attachment Info

1. Type Transmission Code Control Number

Claim Purchased Service Provider Info

Type Name Last First MI ID Ref ID

Claim State Regulatory Info - K3

1 2 3 4 5

Service Line Drug Info

Procedures	NDC	Unit/Type	Price	Prescription	Compound Drug	Date
1 80047 26						MM/DD/YYYY
2 85004 26						MM/DD/YYYY
3 85007 26						MM/DD/YYYY
4 81000 26						MM/DD/YYYY
5 80047 26						MM/DD/YYYY

Table 7 Other Info > General Screen Field Descriptions (HFS 1443 Crosswalk)

HFS 1443 FL#	HFS 1443 Field Description	CMS 1500 FL#	Claim Master Field Description
23-2	Proc. Code/NDC	24D-1	NDC

HFS Form 2209

The HFS 2209 claim form is used to submit claims for Transportation services in a hardcopy or paper format to Medicaid IL. The following Type of Service (TOS) entered on the **Service Lines > Original Info** screen identifies the claim as a HFS 2209 claim form in Claim Master.

- 50 = Emergency Ambulance or Helicopter
- 51 = Non-emergency Ambulance
- 52 = Medicar
- 53 = Taxicab
- 54 = Service Car
- 55 = Private Automobile
- 56 = Other

Color-coded visual aids in this chapter identify the fields on the Claim Master claim form screens that:

Highlighted in yellow	Corresponds to the Medicaid Illinois HFS form
Highlighted in green	Required for billing a Medicaid Illinois HFS claim from Claim Master

Patient & Subscriber > Patient and Current Subscriber/Payer Screen

Screen 10 Patient & Subscriber > Patient and Current Subscriber/Payer Screen (HFS 2209 Crosswalk)

Main Menu -> Create New Claim | Wed Dec 08 21:34:24 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | Validate | Save | Exit

Patient and Current Subscriber/Payer | Other Subscribers/Payers... Functions Printing

25. Provider Tax ID: [] Save As: NEW

26. Patient Account [] Freq Type [] 12. Release Info [] Date []

2. Patient Name Last [] First [] MI [] 3. BirthDate [] Sex [] SSN []

5. Address [] City [] St [] Zip [] Country []

Phone [] 8. Status Marital [] Employment [] Student [] Medical Record Num []

10. Related Cause [] Accident State [] Country [] Date [] Hour []

Patient Homebound [] APG [] 10d. Local Use [] DeathDate [] Accident/Injury []

Condition Codes [] Patient Signature Source []

Current Payer [] 1. Subscriber ID [] 13. Assign Benefit []

Provider ID/NPI 1234567893 / 331L00000X

4. Subscriber Name Last [] First [] MI []

Payer Address [] 7. Subscriber Address []

City [] State [] Zip [] Country [] City [] St [] Zip [] Country []

Insurance Type [] Original Reference [] Phone [] 6. Patient Relationship []

23. Prior Auth [] Referral [] 11a. BirthDate [] Sex [] SSN []

Filing Ind [] 11c. Payer Name [] 11. Grp Name [] Nbr [] b. Emp/Sch []

Payer Secondary ID Qual [] ID [] Health Record Num [] Patient ID []

27. Accept Assignment [] Par Agmt [] 31. Signature []

32. Facility [] ID [] 33. ID [] Taxonomy 331L00000X

Pay-To Provider [- SAME AS BILLING PROVIDER -]

**Table 8 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 2209 Crosswalk) (part 1 of 2)**

HFS 2209 FL#	HFS 2209 Field Description	CMS 1500 FL#	Claim Master Field Description
1	Provider Name	33-2	Provider Tax ID (Name)
2	Provider Number	33a	Provider ID/NPI
3	Billing Date	31-2	Date

**Table 8 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 2209 Crosswalk) (part 2 of 2)**

HFS 2209 FL#	HFS 2209 Field Description	CMS 1500 FL#	Claim Master Field Description
4	Provider Reference	26	Patient Account
5	Provider Street	33-3	Provider ID/NPI (Address - Display Provider)
6	Provider City, State, Zip	33-4	Provider ID/NPI (City, State, Zip - Display Provider)
7	Recipient Name (First MI Last)	2	Patient Name Last, First, MI
8	Recipient Number	1a	Subscriber ID
9	Birthdate	3-1	BirthDate
11-4	Prior Authorization Number (Claim)	23	Prior Authorization Number
18-1	Provider Signature (Leave blank)	31-1	Signature
18-2	Date (Leave blank)	31-2	Date
N/A	N/A	Top -1	Payer
N/A	N/A	3-2	Sex
N/A	N/A	4	Subscriber Name Last, First MI
N/A	N/A	5-1	Address
N/A	N/A	5-2	City
N/A	N/A	5-3	State
N/A	N/A	5-4	Zip
N/A	N/A	6	Pat-ins Relation
N/A	N/A	7-1	Subscriber Address
N/A	N/A	7-2	City
N/A	N/A	7-3	State
N/A	N/A	7-4	Zip
N/A	N/A	11c	Payer
N/A	N/A	12	Release Info- Date
N/A	N/A	13	Assign Benefit
N/A	N/A	27	Accept Assignment
N/A	N/A	N/A	Freq Type

Patient & Subscriber > Other Subscribers/Payers Screen

Screen 11 Patient & Subscriber > Other Subscribers/Payers Screen (HFS 2209 Crosswalk)

Main Menu -> Create New Claim Wed Oct 27 11:46:41 CDT 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: , Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber Service Lines Other Info Edit/Log Validate Save Exit

Patient and Current Subscriber/Payer | **Other Subscribers/Payers...** Functions Printing

Other Payer 1 9. Subscriber ID 13. Assign Benefit

Provider ID/NPI --PLEASE SET PAYER FIRST--
 Payer Address City State Zip Country
 Insurance Type Original Reference
 23. Prior Auth Referral
 9d. Payer Name MediGap Id
 Filing Ind Payer Ref ID Qual ID

9. Subscriber Name Last First MI
 Subscriber Address City St Zip Country
 Phone Patient Relationship
 9b. BirthDate Sex SSN
 9a. Grp Name Nbr c.Emp/Sch
 Health Record Num Patient ID

COB/Adjudication Payer Status: New Clear Adjudication Date Paid Amount Total Non-Cov
 Approved Allowed Covered Patient Resp Patient Paid
 Discount Per Day Limit Tax Pre-Tax OTAF Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

Other Payer 2 Subscriber ID 13. Assign Benefit

Provider ID/NPI --PLEASE SET PAYER FIRST--
 Payer Address City State Zip Country
 Insurance Type Original Reference
 23. Prior Auth Referral
 Payer Name MediGap Id
 Filing Ind Payer Ref ID Qual ID

Subscriber Name Last First MI
 Subscriber Address City St Zip Country
 Phone Patient Relationship
 BirthDate Sex SSN
 Grp Name Nbr Emp/Sch
 Health Record Num Patient ID

COB/Adjudication Payer Status: New Clear Adjudication Date Paid Amount Total Non-Cov
 Approved Allowed Covered Patient Resp Patient Paid
 Discount Per Day Limit Tax Pre-Tax OTAF Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

Table 9 Patient & Subscriber > Other Subscribers/Payers Screen Field Descriptions (HFS 2209 Crosswalk)

HFS 2209 FL#	HFS 2209 Field Description	CMS 1500 FL#	Claim Master Field Description
12A-1	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
12A-2	Status (Claim)	N/A	Payer ID (Position 4-5)
12A-3	TPL Amount (Claim)	N/A	Paid Amount
12A-4	TPL Date (Claim)	N/A	Adjudication Date
12B-1	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
12B-2	Status (Claim)	N/A	Payer ID (Position 4-5)
12B-3	TPL Amount (Claim)	N/A	Paid Amount
12B-4	TPL Date (Claim)	N/A	Adjudication Date
13	Uncoded TPL Name (Claim)	9d	Payer (Name - Payer ID - Position 1-3 = 999)

Service Lines > Original Lines Screen

Screen 12 Service Lines > Original Lines Screen (HFS 2209 Crosswalk)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 13:12:43 CDT 2010

Provider: QAE MEMORIAL HOSPITAL (436999977) Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: New
 Patient: Patient Control #: TEST426017 0001 Claim #: 7957271
 FromThru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed View All Edits << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber | **Service Lines** | Other Info | Edit/Log | **Validate** | **Save** | **Exit**

Original Lines | Adjustment | Functions | Printing

14. Current Illness Date [MM/DD/YYYY] 15. First Illness Date [MM/DD/YYYY]
 Patient Pregnant? ☐ NO Last Menstrual Date [MM/DD/YYYY]
 17. Referring Doctor Z71908 KAUFFMAN, J
 Attending Doctor Z51288 MONROE, M
 Supervising Doctor
 19. Local Use
 Note Reference Code
 21. Diagnosis 1. [7945] 2. [7945] 3. [73390] 4. [V7231]
 5. [] 6. [] 7. [] 8. []
 9. [] A. [] B. [] C. []

16. Unable to Work From [MM/DD/YYYY] Thru [MM/DD/YYYY]
 Last Work Date [MM/DD/YYYY] Return to Work Date [MM/DD/YYYY]
 18. Hospitalization From [MM/DD/YYYY] Thru [MM/DD/YYYY]
 Care Assumed Date [MM/DD/YYYY] Relinquished Date [MM/DD/YYYY]
 20. Outside Lab? ☐ Charges [] Steri? ☐
 22. Medicaid Resubmission Code [] Ref []
 CLIA Num [] Mammo Cert []
 EPSDT Referral? ☐ Condition Codes [] [] []
 Special Program Code [] Demo Proj. Id []
 Delay Reason Code [] IDE Number []
 Anesthesia Related Procedure Code [] []

	A. Date of Service		B		C		D. Procedures				E	F	G	H		J	Set
	From	To	POS	TOS	EMG	HCPCS	M1	M2	M3	M4	Pntr	Charge	Unit	EPSDT	Plan	Doctor	
1																	
2																	
3																	
4																	
5																	
6																	

Patient Paid: [] Total Purchased: [] 28. Total Charge: [] 29. Amount Paid: [] 30. Balance Due: []

TOTAL PAGES: 1 PAGE LIST: 1 NEW PAGE/LAST PAGE | Delete Line | Copy | Split | Action

Table 10 Service Lines > Original Screen Field Descriptions (HFS 2209 Crosswalk)

HFS 2209 FL#	HFS 2209 Field Description	CMS 1500 FL#	Claim Master Field Description
11-1	Date of Service	24A	Date of Service - From/To
11-2	Cat Serv <u>Allowed values</u> 50 = Emergency Ambulance or Helicopter 51 = Non-emergency Ambulance 52 = Medicar 53 = Taxicab 54 = Service Car 55 = Private Automobile 56 = Other	N/A	TOS (value entered determines HFS Form created)
11-3	Procedure Code	24D-1	HCPCS
11-8	Provider Charge	24F	Charge
11-9 11-11	Orig Place (FIRST position of the FIRST Modifier) Dest Place (SECOND position of the FIRST Modifier)	24D-2	M1, M2, M3, M4
12A-3	TPL Amount (Patient Paid)	N/A	Patient Paid
12A-4	TPL Date (Patient Paid Date)	N/A	Date of Service - From
12B-3	TPL Amount (Patient Paid)	N/A	Patient Paid
12B-4	TPL Date (Patient Paid Date)	N/A	Date of Service - From
14	# Sect (Number of Lines)	N/A	Calculated field
15	Total Charge	28	Total Charge
16	Total Deductions	29	Amount Paid
17	Net Charge	30	Balance Due
N/A	N/A	21-1	Diagnosis
N/A	N/A	24B	POS
N/A	N/A	24E	Pntr
N/A	N/A	24G	Unit

Other Info > Ambulance Screen

Screen 13 Other Info > Ambulance Screen (HFS 2209 Crosswalk)

Main Menu -> Create New Claim | Wed Dec 08 21:35:43 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
Patient: Patient Control #: Claim #:
From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | **Other Info** | Edit/Log | **Validate** | **Save** | **Exit**

General | **Ambulance** | DME | PT/Chiro | Functions | Printing

Claim Ambulance Transport Info

Patient Weight Lbs Transport Code Reason Code Distance Miles
Round Trip Purpose Stretcher Purpose
Vehicle License Number Vehicle License State

Claim Ambulance Certification

<input type="text"/> 01 Patient was admitted to a hospital	<input type="text"/> 02 Patient was bed confined before the ambulance service
<input type="text"/> 03 Patient was bed confined after the ambulance service	<input type="text"/> 04 Patient was moved by stretcher
<input type="text"/> 05 Patient was unconscious or in shock	<input type="text"/> 06 Patient was transported in an emergency situation
<input type="text"/> 07 Patient had to be physically restrained	<input type="text"/> 08 Patient has visible hemorrhaging
<input type="text"/> 09 Ambulance service was medically necessary	<input type="text"/> 12 Patient is confined to a bed or chair
<input type="text"/> 60 Transportation was to the nearest facility	

Claim Ambulance Location Info

Pick-Up Address City State Zip Country
Drop-Off Address City State Zip Country
Location

Service Line Ambulance Transport Info/Certification

Table 11 Other Info > Ambulance Screen Field Descriptions (HFS 2209 Crosswalk)

HFS 2209 FL#	HFS 2209 Field Description	CMS 1500 FL#	Claim Master Field Description
11-7	Total Loaded Miles	N/A	Distance (Miles)
11-10	Pick-Up Address (Street)	N/A	Origin (Street)
11-10	Pick-Up Address (City)	N/A	Origin (City)
11-10	Pick-Up Address (State)	N/A	Origin (State)
11-10	Pick-Up Address (Zip)	N/A	Origin (Zip)
11-12	Drop-Off Address (Street)	N/A	Destination (Street)
11-12	Drop-Off Address (City)	N/A	Destination (City)
11-12	Drop-Off Address (State)	N/A	Destination (State)
11-12	Drop-Off Address (Zip)	N/A	Destination (Zip)
N/A	N/A	N/A	Transport Code
N/A	N/A	N/A	Reason Code
N/A	N/A	N/A	Yes/No
N/A	N/A	N/A	Certification Code

Other Info > General Screen

Screen 14 Other Info > General Screen (HFS 2209 Crosswalk)

Provider: KEVIN A. SMITH MD (789654237)		Payer: AETNA - ALL (F6005400)		P/S: P	Status: New
Patient: SMITH, JOE A		Patient Control #: EDIT 21C991V 0008		Claim #: 8392977	
From/Thru: 11/11/10 - 11/11/10		Lines: 4		Total Chg: \$150.50	Est Amt Due: \$150.50

Patient & Subscriber	Service Lines	Other Info	Edit/Log	<input type="button" value="Validate"/> <input type="button" value="Save"/> <input type="button" value="Exit"/>
General Ambulance DME PT/Chiro				

Claim Additional Info

Last Seen Date
 Hearing/Vision Rx Date
 Newborn Weight Grams
 Care Plan Oversight

Referral Number
 Authorization Exception Code
 Property & Casualty Claim Num

Claim Contract Info

Type
 Amount
 Percent
 Code
 Discount Percent
 Version

Claim Patient Vision Condition Info

1. Category
 Indicator
 Condition Code

Claim Paper Work/Attachment Info

1. Type
 Transmission Code
 Control Number

Claim Purchased Service Provider Info

Type
 Name Last
 First
 MI
 ID
 Ref ID

Claim State Regulatory Info - K3

1
 2
 3
 4
 5

Procedures	NDC	Unit/Type	Price	Prescription	Compound Drug	Date
1 84436 TC						MM/DD/YYYY
2 84439 26						MM/DD/YYYY
3 84443 24						MM/DD/YYYY
4 84479 TC 26						MM/DD/YYYY

[Append More Drug Elements...](#)

Service Line Additional Info 1

Procedures	CoPay Status	Hospice Ind	Product Num	Vendor Num	Sales Tax Amt	Purch Serv Amt	Purch Serv Provider
1 84436 TC	<input type="text"/>	<input type="text"/>					
2 84439 26	<input type="text"/>	<input type="text"/>					
3 84443 24	<input type="text"/>	<input type="text"/>					
4 84479 TC 26	<input type="text"/>	<input type="text"/>					

Service Line Additional Info 2

Procedures	Last Seen Date	Current Illness Date	First Illness Date	Referring Doctor	Supervising Doctor	Ordering Doctor
1 84436 TC	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
2 84439 26	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
3 84443 24	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
4 84479 TC 26	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			

Service Line Additional Info 3

Procedures	Description	OB Anes Units	Control Num	APG	Mammo Cert	Clia Num	Refer Clia Num
1 84436 TC							
2 84439 26							
3 84443 24							
4 84479 TC 26							

Service Line Additional Info 4

Procedures	Payer	Prior Auth Num	Referral Num
1 84436 TC	1.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		
2 84439 26	2.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		
3 84443 24	3.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		
4 84479 TC 26	4.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		

Table 12 Other Info > General Screen Field Descriptions (HFS 2209 Crosswalk)

HFS 2209 FL#	HFS 2209 Field Description	CMS 1500 FL#	Claim Master Field Description
11-4	Prior Approval Number (Line)	N/A	Prior Auth Num

HFS Form 2210

The HFS 2210 claim form is used to submit claims for Medical Equipment/Medical Supplies services in a hardcopy or paper format to Medicaid IL. The following Type of Service (TOS) entered on the **Service Lines > Original Info** screen identifies the claim as a HFS 2210 claim form in Claim Master.

41 = Medical Equipment or Prosthetic Devices,
48 = Medical Supplies

Color-coded visual aids in this chapter identify the fields on the Claim Master claim form screens that:

Highlighted in yellow	Corresponds to the Medicaid Illinois HFS form
Highlighted in green	Required for billing a Medicaid Illinois HFS claim from Claim Master

The Medicaid Illinois HFS form specific data elements listed below were not added to the Claim Master claim form screens as the Payer requires the field to be blank upon submission.

.

HFS 2210 FL#	HFS 2210 Field Description
8-6	Cr Child (Leave blank)
8-12	Order Number (Leave blank)

Patient & Subscriber > Patient and Current Subscriber/Payer Screen

Screen 15 Patient & Subscriber > Patient and Current Subscriber/Payer Screen (HFS 2210 Crosswalk)

Main Menu -> Create New Claim | Wed Dec 08 21:34:24 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber Service Lines Other Info Edit/Log **Validate** **Save** **Exit**

Patient and Current Subscriber/Payer | Other Subscribers/Payers... Functions Printing

25. Provider Tax ID: [REDACTED] Save As: NEW

26. Patient Account [REDACTED] Freq Type [REDACTED] 12. Release Info [REDACTED] Date [REDACTED]

2. Patient Name Last [REDACTED] First [REDACTED] MI [REDACTED] 3. BirthDate [REDACTED] Sex [REDACTED] SSN [REDACTED]

5. Address [REDACTED] City [REDACTED] St [REDACTED] Zip [REDACTED] Country [REDACTED]

Phone [REDACTED] 8. Status Marital [REDACTED] Employment [REDACTED] Student [REDACTED] Medical Record Num [REDACTED]

10. Related Cause [REDACTED] Accident State [REDACTED] Country [REDACTED] Date [REDACTED] Hour [REDACTED]

Patient Homebound [REDACTED] APG [REDACTED] 10d. Local Use [REDACTED] DeathDate [REDACTED] Accident/Inj [REDACTED]

Condition Codes [REDACTED] Patient Signature Source [REDACTED]

Current Payer MEDICAID IL (HEALTH FAMILY) (D0062100) 1. Subscriber ID [REDACTED] 13. Assign Benefit [REDACTED]

Provider ID/NPI [REDACTED]

Payer Address [REDACTED]

City [REDACTED] State [REDACTED] Zip [REDACTED] Country [REDACTED]

Insurance Type [REDACTED] Original Reference [REDACTED]

23. Prior Auth [REDACTED] Referral [REDACTED]

Filing Ind [REDACTED] 11c. Payer Name [REDACTED]

Payer Secondary ID Qual [REDACTED] ID [REDACTED]

4. Subscriber Name Last [REDACTED] First [REDACTED] MI [REDACTED]

7. Subscriber Address [REDACTED]

City [REDACTED] St [REDACTED] Zip [REDACTED] Country [REDACTED]

Phone [REDACTED] 6. Patient Relationship [REDACTED]

11a. BirthDate [REDACTED] Sex [REDACTED] SSN [REDACTED]

11. Grp Name [REDACTED] Nbr [REDACTED] b.Emp/Sch [REDACTED]

Health Record Num [REDACTED] Patient ID [REDACTED]

27. Accept Assignment [REDACTED] Par Agmt [REDACTED] 31. Signature [REDACTED]

32. Facility [REDACTED] ID [REDACTED] 33. ID [REDACTED] Taxonomy [REDACTED]

Pay-To Provider [REDACTED]

Table 13 Patient & Subscriber > Patient and Current Subscriber/Payer Screen Field Descriptions (HFS 2210 Crosswalk) (part 1 of 3)

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
1	Provider Name	33-2	Provider Tax ID (Name)
2	Provider Number	33a	Provider ID/NPI
3	Payee	N/A	Pay-To Provider (Display Provider)

**Table 13 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 2210 Crosswalk) (part 2 of 3)**

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
4	Billing Date	31-2	Date
5	Provider Reference	26	Patient Account
6	Provider Street	33-3	Provider ID/NPI (Address - Display Provider)
7	Provider City, State, Zip	33-4	Provider ID/NPI (City, State, Zip - Display Provider)
8-1	Recipient Name (First MI Last)	2	Patient Name Last, First MI
8-2	Recipient Number	1a	Subscriber ID
8-3	Birthdate	3-1	Birthdate
8-4	Accident/Injury <u>Allowed values</u> 1 = Employment related accident or illness 2 = Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle 3 = Injury due to participation in an organized sport or school activity 4 = Injury due to an act of violence (non-accidental) 5 = Injury is the result of an unspecified accident	N/A	Accident/Injury
8-13	Prior Approval	23	Prior Authorization Number
18-1	Provider Signature (Leave blank)	31-1	Signature
18-2	Date (Leave blank)	31-2	Date
N/A	N/A	Top 1	Payer
N/A	N/A	3-2	Sex
N/A	N/A	4	Subscriber Name Last, First, MI
N/A	N/A	5-1	Address
N/A	N/A	5-2	City
N/A	N/A	5-3	State
N/A	N/A	5-4	Zip
N/A	N/A	6	Pat-ins Relation
N/A	N/A	7-1	Subscriber Address
N/A	N/A	7-2	City
N/A	N/A	7-3	State
N/A	N/A	7-4	Zip
N/A	N/A	11c	Payer
N/A	N/A	12	Release Info - Date

**Table 13 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 2210 Crosswalk) (part 3 of 3)**

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
N/A	N/A	13	Assign Benefit
N/A	N/A	27	Accept Assignment
N/A	N/A	N/A	Freq Type

Patient & Subscriber > Other Subscribers/Payers Screen




Screen 16 Patient & Subscriber > Other Subscribers/Payers Screen (HFS 2210 Crosswalk)

Main Menu -> Create New Claim | Wed Oct 27 11:46:41 CDT 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: , Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | **Validate** | **Save** | **Exit**

Patient and Current Subscriber/Payer | **Other Subscribers/Payers...** | Functions | Printing

Other Payer 1 |  | **9. Subscriber ID** |  | **13. Assign Benefit** | 

Provider ID/NPI --PLEASE SET PAYER FIRST-- | **9. Subscriber Name Last** | **First** | **MI** | ☐

Payer Address | **Subscriber Address** | **City** | **St** | **Zip** | **Country** | **Phone** | **Patient Relationship** | ☐

Insurance Type | **Original Reference** | **9b. BirthDate** | **Sex** | **SSN** | ☐

23. Prior Auth | **Referral** | **9a. Grp Name** | **Nbr** | **c.Emp/Sch** | ☐

9d. Payer Name | **MediGap Id** | **Health Record Num** | **Patient ID** | ☐




Filing Ind | **Payer Ref ID Qual** | **ID** | ☐

COB/Adjudication | **Payer Status** | **New** | **Clear** | **Adjudication Date** | **Paid Amount** | **Total Non-Cov** | ☐

Approved | **Allowed** | **Covered** | **Patient Resp** | **Patient Paid** | ☐

Discount | **Per Day Limit** | **Tax** | **Pre-Tax** | **OTAF** | **Patient Liab** | ☐

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

Other Payer 2 |  | **Subscriber ID** |  | **13. Assign Benefit** | 

Provider ID/NPI --PLEASE SET PAYER FIRST-- | **Subscriber Name Last** | **First** | **MI** | ☐

Payer Address | **Subscriber Address** | **City** | **St** | **Zip** | **Country** | **Phone** | **Patient Relationship** | ☐

Insurance Type | **Original Reference** | **BirthDate** | **Sex** | **SSN** | ☐

23. Prior Auth | **Referral** | **Grp Name** | **Nbr** | **Emp/Sch** | ☐

Payer Name | **MediGap Id** | **Health Record Num** | **Patient ID** | ☐

Filing Ind | **Payer Ref ID Qual** | **ID** | ☐

COB/Adjudication | **Payer Status** | **New** | **Clear** | **Adjudication Date** | **Paid Amount** | **Total Non-Cov** | ☐

Approved | **Allowed** | **Covered** | **Patient Resp** | **Patient Paid** | ☐

Discount | **Per Day Limit** | **Tax** | **Pre-Tax** | **OTAF** | **Patient Liab** | ☐

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

Table 14 Patient & Subscriber > Other Subscribers/Payers Screen Field Descriptions (HFS 2210 Crosswalk)

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
8-19	TPL Code (Line)	N/A	Payer ID (Position 1-3)
8-20	Status (Line)	N/A	Payer ID (Position 4-5)
9	Uncoded TPL Name (Claim)	9d	Payer (Name - Payer ID - Position 1-3 = 999)
13A	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
13B	Status (Claim)	N/A	Payer ID (Position 4-5)
13C	TPL Amount (Claim)	N/A	Paid Amount
13D	TPL Date (Claim)	N/A	Adjudication Date

Service Lines > Original Lines Screen

Screen 17 Service Lines > Original Lines Screen (HFS 2210 Crosswalk)

Main Menu -> Create New Claim | Fri Jun 11 12:17:26 CDT 2010

Provider: Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
Patient: Patient Control #: Claim #:
From/Thru: Lines: 0 Total Chg: \$0.00 Est Amt Due: \$0.00

Patient & Subscriber | **Service Lines** | Other Info | Edit/Log | **Validate** | **Save** | **Exit**

Original Lines | Adjustment | Functions | Printing

14. Current Illness Date [MM/DD/YYYY] 15. First Illness Date [MM/DD/YYYY]
Patient Pregnant? [] Last Menstrual Date [MM/DD/YYYY]
17. Referring Doctor []
Attending Doctor []
Supervising Doctor []
19. Local Use []
Note Reference Code []
21. Diagnosis 1. [] 2. [] 3. [] 4. []
5. [] 6. [] 7. [] 8. []
9. [] A. [] B. [] C. []

16. Unable to Work From [MM/DD/YYYY] Thru [MM/DD/YYYY]
Last Work Date [MM/DD/YYYY] Return to Work Date [MM/DD/YYYY]
18. Hospitalization From [MM/DD/YYYY] Thru [MM/DD/YYYY]
Care Assumed Date [MM/DD/YYYY] Relinquished Date [MM/DD/YYYY]
20. Outside Lab? [] Charges [] Steri? []
22. Medicaid Resubmission Code [] Ref []
CLIA Num [] Mammo Cert []
EPSDT Referral? [] Condition Codes [] [] []
Special Program Code [] Demo Proj. Id []
Delay Reason Code [] IDE Number []
Anesthesia Related Procedure Code [] []

	A. Date of Service	B.	C.	D. Procedures	E.	F.	G.	H.	J.								
	From	To	POS	TOS	EMG	HCPCS	M1	M2	M3	M4	Pntr	Charge	Unit	EPSDT	Plan	Doctor	Set
1																	
2	[MM/DD/YYYY]	[MM/DD/YYYY]															
3	[MM/DD/YYYY]	[MM/DD/YYYY]															
4	[MM/DD/YYYY]	[MM/DD/YYYY]															
5	[MM/DD/YYYY]	[MM/DD/YYYY]															
6	[MM/DD/YYYY]	[MM/DD/YYYY]															

Patient Paid: [] Total Purchased: [] 28. Total Charge: [] 29. Amount Paid: [] 30. Balance Due: []

TOTAL PAGES: 1 PAGE LIST: 1 [NEW PAGE/LAST PAGE](#) [Delete Line](#) ☒ Copy ☐ Split [Action](#)

Table 15 Service Lines > Original Lines Screen Field Descriptions (HFS 2210 Crosswalk)

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
8-5	H. Kids (Leave blank)	24H Upper	EPSDT
8-7	Diagnosis Description	N/A	Diagnosis (Search Diagnosis)
8-8	Prefix	21-1	Diagnosis
8-9	Diag Code		
8-14	Cat Serv <u>Allowed values</u> 41 = Medical Equipment or Prosthetic Devices 48 = Medical Supplies	N/A	TOS (value entered determines HFS Form created)
8-15	Item	24D-1	HCPCS
8-16	Pur/Rent <u>Allowed values</u> 1 = Modifier NU 2 = Modifier RR 3 = Modifier RP 5 = Modifier SC	24D-2	M1, M2, M3, M4
8-17	Quantity	24G	Unit
8-18	Date of Service	24A Lower	Date of Service - From / To
8-23	Provider Charge	24F	Charge
12	Sec # (Line number)	N/A	Calculated field
13C	TPL Amount (Patient Paid)	N/A	Patient Paid
13D	TPL Date (Patient Paid Date)	N/A	Date of Service - From
14	# Sects (Number of Lines)	N/A	Calculated field
15	Total Charge	28	Total Charge
16	Total Deductions	29	Amount Paid
17	Net Charge	30	Balance Due
N/A	N/A	24B	POS
N/A	N/A	24E	Pntr

Service Lines > Adjustment Screen

Screen 18 Service Lines > Adjustment Screen (HFS 2210 Crosswalk)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 12:24:15 CDT 2010

Provider: [REDACTED] Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: Incomplete
 Patient: [REDACTED] Patient Control #: [REDACTED] Claim #: [REDACTED]
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed View All Edits << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber Service Lines Other Info Edit/Log Validate Save Exit

Original Lines | Adjustment Functions Printing

DOS From	DOS To	POS	TOS	HCPCS	M1	M2	M3	M4	Charge	Unit	Approved	OTAF
1	20070516	20070516	22	77080					68.80	1 UN	<input type="checkbox"/>	<input type="checkbox"/>

HFS Adjustment --- Print Overlay Print Image

6. Voucher 7. Document Control Number 14. Adj Type 15. Item or Service
 20. Reason Adjustment Requested: 16. Quantity 17. Charges 18. TPL 19. TPL Amt

1. Adjudication Payer -- PLEASE SELECT A PAYER -- Add Clear Adjudication Date Paid Amount
 HCPCS M1 M2 M3 M4 Paid Units Bundled Line # Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

28. Total Charge: 68.80 29. Amount Paid: 30. Balance Due: 68.80

Table 16 Service Lines > Adjustment Screen Field Descriptions (HFS 2210 Crosswalk)

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
8-21	TPL Amount (Line)	N/A	Paid Amount
8-22	TPL Date (Line)	N/A	Adjudication Date
13C	TPL Amount (Line)	N/A	Paid Amount
13D	TPL Date (Line)	N/A	Adjudication Date

Other Info > General Screen

Screen 19 Other Info > General Screen (HFS 2210 Crosswalk)

Provider: KEVIN A SMITH MD (789654237)		Payer: AETNA - ALL (F6005400)		P/S: P	Status: New
Patient: SMITH, JOE A		Patient Control #: EDIT 21C991V 0008		Claim #: 8392977	
From/Thru: 11/11/10 - 11/11/10		Lines: 4		Total Chg: \$150.50	Est Amt Due: \$150.50

Patient & Subscriber	Service Lines	Other Info	Edit/Log	<input type="button" value="Validate"/> <input type="button" value="Save"/> <input type="button" value="Exit"/>
General Ambulance DME PT/Chiro				

Claim Additional Info

Last Seen Date
 Hearing/Vision Rx Date
 Newborn Weight Grams
 Care Plan Oversight

Referral Number
 Authorization Exception Code
 Property & Casualty Claim Num

Claim Contract Info

Type
 Amount
 Percent
 Code
 Discount Percent
 Version

Claim Patient Vision Condition Info

1. Category
 Indicator
 Condition Code

Claim Paper Work/Attachment Info

1. Type
 Transmission Code
 Control Number

Claim Purchased Service Provider Info

Type
 Name Last
 First
 MI
 ID
 Ref ID

Claim State Regulatory Info - K3

1
 2
 3
 4
 5

Service Line Drug Info

Procedures	NDC	Unit/Type	Price	Prescription	Compound Drug	Date
1 84436 TC						MM/DD/YYYY
2 84439 26						MM/DD/YYYY
3 84443 24						MM/DD/YYYY
4 84479 TC 26						MM/DD/YYYY

[Append More Drug Elements...](#)

Service Line Additional Info 1

Procedures	CoPay Status	Hospice Ind	Product Num	Vendor Num	Sales Tax Amt	Purch Serv Amt	Purch Serv Provider
1 84436 TC							
2 84439 26							
3 84443 24							
4 84479 TC 26							

Service Line Additional Info 2

Procedures	Last Seen Date	Current Illness Date	First Illness Date	Referring Doctor	Supervising Doctor	Ordering Doctor
1 84436 TC	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
2 84439 26	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
3 84443 24	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
4 84479 TC 26	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			

Service Line Additional Info 3

Procedures	Description	OB Anes Units	Control Num	APG	Mammo Cert	Clia Num	Refer Clia Num
1 84436 TC							
2 84439 26							
3 84443 24							
4 84479 TC 26							

Service Line Additional Info 4

Procedures	Payer	Prior Auth Num	Referral Num
1 84436 TC	1.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		
2 84439 26	2.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		
3 84443 24	3.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		
4 84479 TC 26	4.1 -- PLEASE SELECT A PAYER -- <input type="button" value="Add"/> <input type="button" value="Clear"/>		

Table 17 Other Info > General Screen Field Descriptions (HFS 2210 Crosswalk)

HFS 2210 FL#	HFS 2210 Field Description	CMS 1500 FL#	Claim Master Field Description
8-10	Ordering Practitioner Name	N/A	Ordering Doctor (Name - Search Doctor)
8-11	Ordering Practitioner Number NPI	N/A	Ordering Doctor (NPI - Search Doctor)

HFS Form 2360

The HFS 2360 claim form is used to submit claims for Professional services in a hardcopy or paper format to Medicaid IL. The following Type of Service (TOS) entered on the **Service Lines > Original Info** screen identifies the claim as a HFS 2360 claim form in Claim Master.

- 1 = Medical Care - Attending Physician
- 2 = Surgery - Surgeon
- 3 = Consultation - Consultant
- 4 = Diagnostic X-Ray - Radiologist
- 5 = Diagnostic Laboratory - Pathologist
- 7 = Anesthesia - Anesthesiologist
- 8 = Assistance at Surgery - Surgical Assistant
- 9 = Other Medical Service
- S = Co-Surgeon
- Y = Second Opinion on Elective Surgery
- G = Concurrent Care

Color-coded visual aids in this chapter identify the fields on the Claim Master claim form screens that:

Highlighted in yellow	Corresponds to the Medicaid Illinois HFS form
Highlighted in green	Required for billing a Medicaid Illinois HFS claim from Claim Master

The Medicaid Illinois HFS form specific data elements listed below were not added to the Claim Master claim form screens as the Payer requires the field to be blank upon submission.

HFS 2360 FL#	HFS 2360 Field Description
2-2	Age (Leave blank)
16-1	Has Patient Ever Had Same or Similar Symptom (Leave blank)
17	Date Patient Able To Return To Work (Leave blank)
18-2	Dates of Partial Disability From/Thru (Leave blank)
36	Original Voucher Number (Leave blank)

Patient & Subscriber > Patient and Current Subscriber/Payer Screen

Screen 20 Patient & Subscriber > Patient and Current Subscriber/Payer Screen (HFS 2360 Crosswalk)

Main Menu -> Create New Claim		Wed Dec 08 21:34:24 CST 2010	
Provider: THE DOCTOR'S OFFICE (460447693) Patient: , From/Thru:		Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Patient Control #: Lines: 0 Total Chg:	
		Status: New Claim #: Est Amt Due:	

Patient & Subscriber		Service Lines	Other Info	Edit/Log	Validate	Save	Exit
Patient and Current Subscriber/Payer Other Subscribers/Payers...							
Functions Printing							

25. Provider Tax ID:
Save As: NEW

26. Patient Account [redacted] Freq Type [redacted]

12. Release Info [redacted] Date [redacted]

2. Patient Name Last [redacted] First [redacted] MI [redacted]

3. BirthDate [redacted] Sex [redacted] SSN [redacted]

5. Address [redacted] City [redacted] St [redacted] Zip [redacted] Country [redacted]

Phone [redacted]

8. Status Marital [redacted] Employment [redacted] Student [redacted]

Medical Record Num [redacted]

10. Related Cause [redacted] Accident State [redacted] Country [redacted] Date [redacted] Hour [redacted]

Patient Homebound [redacted] APG [redacted]

10d. Local Use [redacted] DeathDate [redacted] Accident/Injury [redacted]

Condition Codes [redacted] Patient Signature Source [redacted]

Current Payer: MEDICAID IL (HEALTH FAMILY) (D0062100)

Provider ID/NPI [redacted]
 Payer Address [redacted]
 City [redacted] State [redacted] Zip [redacted] Country [redacted]
 Insurance Type [redacted] Original Reference [redacted]
 23. Prior Auth [redacted] Referral [redacted]
 Filing Ind [redacted] 11c. Payer Name [redacted]
 Payer Secondary ID Qual [redacted] ID [redacted]

1. Subscriber ID [redacted]
 4. Subscriber Name Last [redacted] First [redacted] MI [redacted]
 7. Subscriber Address [redacted]
 City [redacted] St [redacted] Zip [redacted] Country [redacted]
 Phone [redacted]

13. Assign Benefit [redacted]
 6. Patient Relationship [redacted]
 11a. BirthDate [redacted] Sex [redacted] SSN [redacted]
 11. Grp Name [redacted] Nbr [redacted] b.Emp/Sch [redacted]
 Health Record Num [redacted] Patient ID [redacted]

27. Accept Assignment [redacted] Par Agmt [redacted]

31. Signature [redacted]

32. Facility [redacted] ID [redacted]

33. ID [redacted] Taxonomy [redacted]

Pay-To Provider [redacted]

[redacted]

**Table 18 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 2360 Crosswalk) (part 1 of 2)**

HFS 2360 FL#	HFS 2360 Field Description	CMS 1500 FL#	Claim Master Field Description
1	Patient's Name (First MI Last)	2	Patient Name, Last, First, MI
2-1	Patient's Date of Birth	3-1	Birth Date
3	Subscriber's Name (First MI Last)	4	Subscribers Name Last, First, MI
4-1	Patient's Address (Street)	5-1	Address
4-2	Patient's Address (City)	5-2	City
4-2	Patient's Address (State)	5-3	State
4-3	Patient's Address (Zip Code)	5-4	Zip
4-4	Patient's Address (Telephone)	5-5	Phone
5	Patient's Sex	3-2	Sex
7	Patient Relation To Subscriber	6	Pat-Ins Relation
8	Subscriber's Group No. (Group Name) And/Or Medicaid No.	1a'	Subscriber ID
10A	Patient Employment	10a	Related Cause
10B-1	Accident Auto	10b-1	Related Cause
10B-2	Accident Other	10c	Related Cause
11-1	Subscriber's Address (Street)	7-1	Subscriber Address
11-2	Subscriber's Address (City)	7-2	City
11-3	Subscriber's Address (State)	7-3	State
11-4	Subscriber's Address (Zip Code)	7-4	Zip
12	Patient's or Authorized Person's Signature - Date (Release)	12	Release Info - Date
13	Subscriber's or Authorized Person's Signature (Assign Benefits)	13	Assign Benefits
14	Date Injury (Accident)	14	Accident Date
21	Name and Address of Facility Where Services Rendered	32-1	Facility (Name - Search Facility)
23D	Prior Authorization Number	23	Prior Authorization Number
25-1	Signature of Physician or Supplier (Leave blank)	31-1	Signature
25-2	Date (Leave blank)	31-2	Date
26	Accept Assignment	27	Accept Assignment
30	Your Provider Number	33a	Provider ID NPI
31-1	Physician's or Supplier's Name	33-2	Provider Tax ID (Name)
31-2	Physician's or Supplier's Address	33-3	Provider ID NPI (Address - Display Provider)
31-3	Physician's or Supplier's City, State, Zip Code	33-4	Provider ID NPI (City, State, Zip Code)
32	Your Patient Account Number	26	Patient Account

**Table 18 Patient & Subscriber > Patient and Current Subscriber/Payer Screen
Field Descriptions (HFS 2360 Crosswalk) (part 2 of 2)**

HFS 2360 FL#	HFS 2360 Field Description	CMS 1500 FL#	Claim Master Field Description
33	Payee Number	N/A	Pay-To-Provider (Display Provider)
35	Original DCN	22-2	Original Reference
N/A	N/A	Top 1	Payer
N/A	N/A	11c	Payer
N/A	N/A	N/A	Freq Type

Patient & Subscriber > Other Subscribers/Payers Screen




Screen 21 Patient & Subscriber > Other Subscribers/Payers Screen (HFS 2360 Crosswalk)

Main Menu -> Create New Claim | Wed Oct 27 11:46:41 CDT 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: ; Patient Control #: Claim #:
 From/Thru: Lines: 0 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | **Validate** | **Save** | **Exit**




Patient and Current Subscriber/Payer | **Other Subscribers/Payers...** | Functions | Printing

Other Payer 1 |  | **9. Subscriber ID** |  | **13. Assign Benefit** | 

Provider ID/NPI --PLEASE SET PAYER FIRST-- | 9. Subscriber Name Last | First | MI |
 Payer Address | Subscriber Address |
 City | State | Zip | - | Country | City | St | Zip | - | Country | - |
 Insurance Type | Original Reference | Phone | Patient Relationship |
 23. Prior Auth | Referral | 9b. BirthDate | MM/DD/YYYY | Sex | | SSN |
 9d. Payer Name | MediGap Id | 9a. Grp Name | Nbr | c.Emp/Sch |
 Filing Ind | Payer Ref ID Qual | ID | Health Record Num | Patient ID |

COB/Adjudication | Payer Status: New | Clear | Adjudication Date | Paid Amount | Total Non-Cov |
 Approved | Allowed | Covered | Patient Resp | Patient Paid |
 Discount | Per Day Limit | Tax | Pre-Tax | OTAF | Patient Liab |

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

Other Payer 2 |  | **Subscriber ID** |  | **13. Assign Benefit** | 

Provider ID/NPI --PLEASE SET PAYER FIRST-- | Subscriber Name Last | First | MI |
 Payer Address | Subscriber Address |
 City | State | Zip | - | Country | City | St | Zip | - | Country | - |
 Insurance Type | Original Reference | Phone | Patient Relationship |
 23. Prior Auth | Referral | BirthDate | MM/DD/YYYY | Sex | | SSN |
 Payer Name | MediGap Id | Grp Name | Nbr | Emp/Sch |
 Filing Ind | Payer Ref ID Qual | ID | Health Record Num | Patient ID |

COB/Adjudication | Payer Status: New | Clear | Adjudication Date | Paid Amount | Total Non-Cov |
 Approved | Allowed | Covered | Patient Resp | Patient Paid |
 Discount | Per Day Limit | Tax | Pre-Tax | OTAF | Patient Liab |

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

Table 19 Patient & Subscriber > Other Subscribers/Payers Screen Field Descriptions (HFS 2360 Crosswalk)

HFS 2360 FL#	HFS 2360 Field Description	CMS 1500 FL#	Claim Master Field Description
9	Subscriber's ID And/Or Medicare No.	9d	Payer (Name - Payer ID - Position 1-3 = 999)
37A	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
37B	Status (Claim)	N/A	Payer ID (Position 4-5)
37C	TPL Amount (Claim)	N/A	Paid Amount
37D	TPL Date (Claim)	N/A	Adjudication Date
38A	TPL Code (Claim)	N/A	Payer ID (Position 1-3)
38B	Status (Claim)	N/A	Payer ID (Position 4-5)
38C	TPL Amount (Claim)	N/A	Paid Amount
38D	TPL Date (Claim)	N/A	Adjudication Date

Service Lines > Original Lines Screen

Screen 22 Service Lines > Original Lines Screen (HFS 2360 Crosswalk)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 13:12:43 CDT 2010

Provider: [REDACTED] Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: New
 Patient: [REDACTED] Patient Control #: [REDACTED] Claim #: [REDACTED]
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed [View All Edits](#) << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber | **Service Lines** | Other Info | Edit/Log | **Validate** | **Save** | **Exit**

Original Lines | Adjustment | Functions | Printing

14. Current Illness Date [REDACTED] 15. First Illness Date [REDACTED] 16. Unable to Work From [REDACTED] Thru [REDACTED]
 Patient Pregnant? ☐ NO Last Menstrual Date [REDACTED]
 17. Referring Doctor [REDACTED] 18. Hospitalization From [REDACTED] Thru [REDACTED]
 Care Assumed Date [REDACTED] Relinquished Date [REDACTED]
 20. Outside Lab? ☐ Charges [REDACTED] Steri? ☐
 22. Medicaid Resubmission Code [REDACTED] Ref [REDACTED]
 CLIA Num [REDACTED] Mammo Cert [REDACTED]
 EPSDT Referral? ☐ Condition Codes [REDACTED] [REDACTED] [REDACTED]
 Special Program Code [REDACTED] Demo Proj. Id [REDACTED]
 Delay Reason Code [REDACTED] IDE Number [REDACTED]
 Anesthesia Related Procedure Code [REDACTED] [REDACTED]

19. Local Use [REDACTED]
 Note Reference Code [REDACTED]

21. Diagnosis 1. [REDACTED] 2. [REDACTED] 3. 73390 4. V7231
 5. [REDACTED] 6. [REDACTED] 7. [REDACTED] 8. [REDACTED]
 9. [REDACTED] A. [REDACTED] B. [REDACTED] C. [REDACTED]

	A. Date of Service		B		C		D. Procedures					E	F	G	H		J	Set
	From	To	POS	TOS	EMG	HCPCS	M1	M2	M3	M4	Pntr	Charge	Unit	EPSDT	Plan	Doctor		
1	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
2	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
3	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
4	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
5	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
6	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

Patient Paid: [REDACTED] Total Purchased: [REDACTED] 28. Total Charge: [REDACTED] 29. Amount Paid: [REDACTED] 30. Balance Due: [REDACTED]

TOTAL PAGES: 1 PAGE LIST: 1 [NEW PAGE/LAST PAGE](#) [Delete Line](#) [Copy](#) [Split](#) [Action](#)

Table 20 Service Lines > Original Lines Screen Field Descriptions (HFS 2360 Crosswalk) (part 1 of 2)

HFS 2360 FL#	HFS 2360 Field Description	CMS 1500 FL#	Claim Master Field Description
14	Date Illness (First Symptom) or Date Pregnancy (LMP)	14	Current Illness Date Last Menstrual Date
15	Date First Consulted You For This Condition	15	First Illness Date
16-2	Check if Emergency	24C	EMG
18-1	Dates of Total Disability From/Thru	16	Unable to Work From/Thru
19-1	Name of Referring Physician or Other Source	17	Referring Doctor (NPI - Search Order)
19-2	Provider Number	17b	Referring Doctor (NPI - Search Doctor)
20	For Services Related to Hospitalization Give Hospitalization Dates (Admitted/Discharged)	18	Hospitalization From/Thru
22-1	Was Laboratory Work Performed Outside Your Office	20-1	Outside Lab?
22-2	Charges	20-2	Charges
23A	Healthy Kids Services	24H Upper	EPSDT
23B	Family Planning	24H Lower	Plan
23C	Sterilization/Abortion	N/A	Steri?
23E	TOS (Type of Service) <u>Allowed Values</u> 1 = Medical Care - Attending Physician 2 = Surgery - Surgeon 3 = Consultation - Consultant 4 = Diagnostic X-Ray - Radiologist 5 = Diagnostic Laboratory - Pathologist 7 = Anesthesia - Anesthesiologist 8 = Assistance at Surgery - Surgical Assistant 9 = Other Medical Service S = Co-Surgeon Y = Second Opinion on Elective Surgery G = Concurrent Care	N/A	TOS (value entered determines HFS Form created)
23F	Primary Diagnosis Description	N/A	Diagnosis (Search Diagnosis)

Table 20 Service Lines > Original Lines Screen Field Descriptions (HFS 2360 Crosswalk) (part 2 of 2)

HFS 2360 FL#	HFS 2360 Field Description	CMS 1500 FL#	Claim Master Field Description
24A	Date of Service	24A Lower	Date of Service - From/Thru
24B	POS (Place of Service) <u>Allowed values</u> 11 = Office 12 = Home 13 = Assisted Living Facility 14 = Group Home 21 = Inpatient Hospital 22 = Outpatient Hospital 31 = Skilled Nursing Facility 32 = Nursing Facility 33 = Custodial Care Facility	24B	POS
24C-1	Procedure Code	24D-1	HCPCS
24C-2	MOD	24D-2	M1, M2, M3, M4
24C-3	Procedure Description	N/A	HCPCS (Search HCPCS)
24D-1	Diagnosis Code (Primary)	21-1	Diagnosis
24D-2	Diagnosis Code (Secondary)	21-2	Diagnosis
24E	Charges	24F	Charges
24F	Days or Units	24G	Unit
27	Total Charges	28	Total Charges
28	Amount Paid	29	Amount Paid
29	Balance Due	30	Balance Due
34	Number of Sections (Number of lines)	N/A	Calculated field
37C	TPL Amount (Patient Paid)	N/A	Patient Paid
37D	TPL Date (Patient Paid Date)	N/A	Date of Service - From
38C	TPL Amount (Patient Paid)	N/A	Patient Paid
38D	TPL Date (Patient Paid Date)	N/A	Date of Service - From
N/A	N/A	24E	Pntr

Other Info > General Screen

Screen 23 Other Info > General Screen (HFS 2360 Crosswalk)

Main Menu -> Search Claim -> Edit Claim Fri Sep 24 10:36:34 CDT 2010

Provider: [Text] Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: Submitted
 Patient: [Text] Patient Control #: [Text] Claim #: [Text]
 From/Thru: 05/05/10 - 05/05/10 Lines: 1 Total Chg: \$20.00 Est Amt Due: \$20.00

Patient & Subscriber | Service Lines | **Other Info** | Edit/Log Validate Save Exit

General | Ambulance | DME | PT/Chiro Functions Printing

Claim Additional Info

Last Seen Date [Text] Hearing/Vision Rx Date [Text] Newborn Weight [Text] Grams Care Plan Oversight [Text]
 Referral Number [Text] Authorization Exception Code [Text] Property & Casualty Claim Num [Text]

Claim Contract Info

Type [Text] Amount [Text] Percent [Text] Code [Text] Discount Percent [Text] Version [Text]

Claim Patient Vision Condition Info

1. Category [Text] Indicator [Text] Condition Code [Text]

Claim Paper Work/Attachment Info

1. Type [Text] Transmission Code [Text] Control Number [Text]

Claim Purchased Service Provider Info

Type [Text] Name Last [Text] First [Text] MI [Text] ID [Text] Ref ID [Text]

Claim State Regulatory Info - K3

1 [Text] 2 [Text] 3 [Text] 4 [Text] 5 [Text]

Service Line Drug Info

Procedures	NDC	Unit/Type	Price	Prescription	Compound Drug	Date
1 85004 28						

[Append More Drug Elements](#)

Table 21 Other Info > General Screen Field Descriptions (HFS 2360 Crosswalk)

HFS 2360 FL#	HFS 2360 Field Description	CMS 1500 FL#	Claim Master Field Description
24C-1	Procedure Code (NDC)	24D-1	NDC

HFS Form 2292

The HFS 2292 adjustment form is used to file adjustments for all Professional services in a hardcopy or paper format to Medicaid IL.

A color-coded visual aid in this chapter identifies the fields on the Claim Master claim form screens that:

Highlighted in yellow	Required for filling an adjustment to Medicaid Illinois HFS from Claim Master
-----------------------	---

The Medicaid Illinois HFS form specific data elements listed below were not added to the Claim Master claim form screens as the Payer requires the field to be blank upon submission.

HFS 2292 FL#	HFS 2292 Field Description
1	Document Control Number (Leave blank)
23	HFS Use Only (Leave blank)
24	HFS Use Only (Leave blank)
25	HFS Use Only (Leave blank)
26	HFS Use Only (Leave blank)
27	HFS Use Only (Leave blank)
28	HFS Use Only (Leave blank)
29	HFS Use Only (Leave blank)
30	HFS Use Only (Leave blank)
31	HFS Use Only (Leave blank)
32	HFS Use Only (Leave blank)
33	HFS Use Only (Leave blank)
34	HFS Use Only (Leave blank)
35	HFS Use Only (Leave blank)
36	HFS Use Only (Leave blank)
37	HFS Use Only (Leave blank)

Patient & Subscriber > Patient and Current Subscriber/Payer Screen

Screen 24 Patient & Subscriber > Patient and Current Subscriber/Payer Screen (HFS 2292 Crosswalk)

Main Menu -> Create New Claim		Wed Dec 08 21:34:24 CST 2010	
Provider: THE DOCTOR'S OFFICE (460447693)	Payer: MEDICAID IL (HEALTH FAMILY) (D0062100)	P/S: P	Status: New
Patient: ,	Patient Control #:		Claim #:
From/Thru:	Lines: 0	Total Chg:	Est Amt Due:
Patient & Subscriber Service Lines Other Info Edit/Log		Validate Save Exit	
Patient and Current Subscriber/Payer Other Subscribers/Payers...		Functions Printing	
25. Provider Tax ID: [REDACTED]		Save As: NEW	
26. Patient Account [REDACTED] Freq Type [REDACTED]		12. Release Info [REDACTED] Date [REDACTED]	
2. Patient Name Last [REDACTED] First [REDACTED] MI [REDACTED]		3. BirthDate [REDACTED] Sex [REDACTED] SSN [REDACTED]	
5. Address [REDACTED] City [REDACTED] St [REDACTED] Zip [REDACTED] Country [REDACTED]			
Phone [REDACTED] 8. Status Marital [REDACTED] Employment [REDACTED] Student [REDACTED] Medical Record Num [REDACTED]			
10. Related Cause [REDACTED] Accident State [REDACTED] Country [REDACTED] Date [REDACTED] Hour [REDACTED]			
Patient Homebound [REDACTED] APG [REDACTED] 10d. Local Use [REDACTED] DeathDate [REDACTED] Accident/Injury [REDACTED]			
Condition Codes [REDACTED] Patient Signature Source [REDACTED]			
Current Payer: MEDICAID IL (HEALTH FAMILY) (D0062100)		1. Subscriber ID [REDACTED] 13. Assign Benefit [REDACTED]	
Provider ID/NPI [REDACTED]		4. Subscriber Name Last [REDACTED] First [REDACTED] MI [REDACTED]	
Payer Address [REDACTED]		7. Subscriber Address [REDACTED]	
City [REDACTED] State [REDACTED] Zip [REDACTED] Country [REDACTED]		City [REDACTED] St [REDACTED] Zip [REDACTED] Country [REDACTED]	
Insurance Type [REDACTED] Original Reference [REDACTED]		Phone [REDACTED] 6. Patient Relationship [REDACTED]	
23. Prior Auth [REDACTED] Referral [REDACTED]		11a. BirthDate [REDACTED] Sex [REDACTED] SSN [REDACTED]	
Filing Ind [REDACTED] 11c. Payer Name [REDACTED]		11. Grp Name [REDACTED] Nbr [REDACTED] b. Emp/Sch [REDACTED]	
Payer Secondary ID Qual [REDACTED] ID [REDACTED]		Health Record Num [REDACTED] Patient ID [REDACTED]	
27. Accept Assignment [REDACTED] Par Agmt [REDACTED]		31. Signature [REDACTED]	
32. Facility [REDACTED] ID [REDACTED]		33. ID [REDACTED] Taxonomy [REDACTED]	
Pay-To Provider [REDACTED]			

**Table 22 Patient & Subscriber > Patient and Current Subscriber/Payer
Screen Field Descriptions (HFS 2292 Crosswalk)**

HFS 2292 FL#	HFS 2292 Field Description	Claim Master Field Description
2-1	Provider Name	Provider Tax ID (Name)
2-2	Provider Street	Provider ID/NPI (Address - Display Provider)
2-3	Provider City Provider State Provider Zip	Provider ID/NPI (City, State, Zip - Display Provider)
3	Provider Number	Provider ID/NPI
4	Payee	Pay-To Provider (Display Provider)
5	Provider Reference	Patient Account
11	Recipient Name	Patient Name Last, First, MI
12	Recipient Number	Subscriber ID
13	Date of Birth	BirthDate
21	Provider Signature (Leave blank)	Signature
22	Signature Date (Leave blank)	Date

Service Lines > Original Lines Screen

Screen 25 Service Lines > Original Lines Screen (HFS 2292 Crosswalk)

Main Menu -> Create New Claim Fri Jun 11 12:17:26 CDT 2010

Provider: RURAL HEALTH CLINIC (436999977) Payer: MEDICAID IL (HEALTH FAMILY) (D0062100) P/S: P Status: New
 Patient: , Patient Control #: TEST MEDICAID IL Claim #:
 From/Thru: Lines: 0 Total Chg: \$0.00 Est Amt Due: \$0.00

Patient & Subscriber **Service Lines** Other Info Edit/Log **Validate** **Save** **Exit**

Original Lines | Adjustment Functions ▾ Printing ▾

14. Current Illness Date 15. First Illness Date
 Patient Pregnant? ☐ Last Menstrual Date
 17. Referring Doctor
 Attending Doctor
 Supervising Doctor
 19. Local Use
 Note Reference Code
 21. Diagnosis 1. 2. 3. 4.
 5. 6. 7. 8.
 9. A. B. C.

16. Unable to Work From Thru
 Last Work Date Return to Work Date
 18. Hospitalization From Thru
 Care Assumed Date Relinquished Date
 20. Outside Lab? ☐ Charges Steri? ☐
 22. Medicaid Resubmission Code Ref
 CLIA Num Mammo Cert
 EPSDT Referral? ☐ Condition Codes
 Special Program Code Demo Proj. Id
 Delay Reason Code IDE Number
 Anesthesia Related Procedure Code

	A. Date of Service		B. POS	C. TOS	D. Procedures	E. EMG	F. HCPCS	G. M1	H. M2	I. M3	J. M4	K. Pntr	L. Charge	M. Unit	N. EPSDT	O. Plan	P. Doctor	Q. Set
	From	To																
1																		
2	<input type="text"/>	<input type="text"/>																
3	<input type="text"/>	<input type="text"/>																
4	<input type="text"/>	<input type="text"/>																
5	<input type="text"/>	<input type="text"/>																
6	<input type="text"/>	<input type="text"/>																

Patient Paid: Total Purchased: 28. Total Charge: 0.00 29. Amount Paid: 30. Balance Due: 0.00

TOTAL PAGES: 1 PAGE LIST: 1 [NEW PAGE/LAST PAGE](#) [Delete Line](#) ☒ Copy ☐ Split [Action](#)

**Table 23 Service Lines > Original Lines Screen Field Descriptions
(HFS 2292 Crosswalk)**

HFS 2292 FL#	HFS 2292 Field Description	Claim Master Field Description
9	Date of Service	Date of Service - From/To
10	Item or Service	HCPCS

Service Lines > Adjustment Screen

Screen 26 Service Lines > Adjustment Screen (HFS 2292 Crosswalk)

Main Menu -> Search Claim -> Edit Claim | Fri Jun 11 12:24:15 CDT 2010

Provider: QAE MEMORIAL HOSPITAL (436999977) Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: Incomplete
 Patient: Patient Control #: TEST426017 0001 Claim #: 7957271
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed View All Edits << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber Service Lines Other Info Edit/Log Validate Save Exit

Original Lines | Adjustment Functions Printing

DOS From	DOS To	POS	TOS	HCPCS	M1	M2	M3	M4	Charge	Unit	Approved	OTAF
1	20070516	20070516	22	77080					68.80	1 UN		

HFS Adjustment --- Print Overlay Print Image

6. Voucher 7. Document Control Number 14. Adj Type 15. Item or Service
 20. Reason Adjustment Requested: 16. Quantity 17. Charges 18. TPL 19. TPL Amt

Adjudication Payer -- PLEASE SELECT A PAYER -- Add Clear Adjudication Date Paid Amount
 HCPCS M1 M2 M3 M4 Paid Units Bundled Line # Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

28. Total Charge: 68.80 29. Amount Paid: 30. Balance Due: 68.80

Table 24 Service Lines > Adjustment Screen Field Descriptions (HFS 2292 Crosswalk)

HFS 2292 FL#	HFS 2292 Field Description	Claim Master Field Description
6	Voucher	Voucher
7	Document Control Number	Document Control Number
8	Serv Sect	N/A - Calculated field
14	Adj Type	Adj Type
15	Item or Service	Item or Service
16	Quantity	Quantity
17	Charges	Charges
18	TPL	TPL
19	TPL Amount	TPL
20	Reason Adjustment Requested	Reason Adjustment Requested

Hand-Keying Medicaid Illinois HFS Claims

In addition to its automated Claim Capture functionality, Claim Master allows you to hand-key Medicaid Illinois HFS proprietary claim forms. The order you in which you key in claim information is at your discretion. However, Emdeon recommends the following order for keying in claim information:

1. *Patient & Subscriber*
2. *Service Lines*
3. *Other Info*

Start by clicking on the *Patient & Subscriber* tab and entering Provider and Patient information. When entering information, you may tab to move from one field to the next.

It is not necessary to enter all the information for the claim before saving the claim. If you have an interruption while entering claim information, you may save the claim and access it later to complete it.

- **Patient and Subscriber** - The Patient & Subscriber tab contains demographic information such as address, Payer, provider, and insured's information.
- **Service Lines** - The Service Lines tab contains itemized service/treatment information including HCPCS codes, date of service, and illness dates, doctor information, diagnosis codes, authorization information, and other service data.
- **Other Info** - The Other Info tab consists of four individual screens that contain additional claim information typically not on a printed HCFA form. This information includes General, Ambulance, DME, and PT/Chiro information.

For more detailed descriptions of these screens and crosswalks specific to each Medicaid Illinois HFS proprietary claim form, see [Chapter 1, "Completing Claim Master Screens."](#)

Hand Keying a Medicaid Illinois HFS Claim

- 1 Select the **Create Medicaid IL Claim** option from the Claim Master Main Menu.



The *Patient & Subscriber > Patient and Current Subscriber/Payer* displays.

Screen 27 Patient & Subscriber > Patient and Current Subscriber/Payer Screen

Main Menu -> Create New Medicaid IL Claim | Wed Dec 08 21:38:28 CST 2010

Provider: THE DOCTOR'S OFFICE (460447693) Payer: P/S: P Status: New
 Patient: , Patient Control #: Claim #:
 From/Thru: Lines: 1 Total Chg: Est Amt Due:

Patient & Subscriber | Service Lines | Other Info | Edit/Log | Save | Exit

Patient and Current Subscriber/Payer | Other Subscribers/Payers... | Printing

25. Provider Tax ID: THE DOCTOR'S OFFICE (460447693) Save As: NEW

26. Patient Account | Freq Type 1 - ORIGINAL | 12. Release Info Y - Signed Statement | Date |

2. Patient Name Last | First | MI | 3. BirthDate | Sex | Accident/Injury |

5. Address | City | St | Zip | Country |

Current Payer | 1. Subscriber ID | 13. Assign Benefit Y |

Provider ID/NPI --PLEASE SET PAYER FIRST-- | 4. Subscriber Name Last | First | MI |

Payer Address | 7. Subscriber Address |

City | State | Zip | Country | City | St | Zip | Country |

23. Prior Auth | 6. Patient Relationship 18 Self |

27. Accept Assignment ASSIGNED | 31. Signature |

32. Facility | ID | 33. ID | Taxonomy 251B00000X |

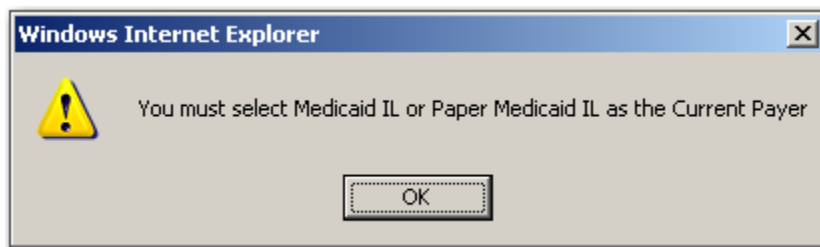
Pay-To Provider -- SAME AS BILLING PROVIDER -- |

2 Enter Patient and Subscriber information into the applicable fields. The following fields will be defaulted:

- Frequency Type = 1 - Original
- Release Information = Y - Signed Statement
- Assign Benefits = Y - Yes
- Patient Relationship = 18 - Self
- Accept Assignment = Assigned

3 Select a Medicaid IL Payer as the current Payer.

The following message will display upon exiting the *Patient & Subscriber > Patient and Current Subscriber/Payer* screen if a Medicaid IL Payer has not been selected.



4 Click the *Service Lines > Original Lines* link.

The *Service Lines > Original Lines* screen displays.

Screen 28 Service Lines > Original Lines Screen

The screenshot shows the 'Original Lines' screen with the following fields and table:

Fields:

- 14. Current Illness Date: [MM/DD/YYYY]
- 15. First Illness Date: [MM/DD/YYYY]
- 16. Unable to Work From: [MM/DD/YYYY] Thru: [MM/DD/YYYY]
- 17. Referring Doctor: [Text]
- 18. Hospitalization From: [MM/DD/YYYY] Thru: [MM/DD/YYYY]
- 21. Diagnosis 1, 2, 3, 4: [Dropdowns]
- 20. Outside Lab?: [Dropdown] Charges: [Text] Steri?: [Dropdown]

Table:

	A. Date of Service		B		C	D. Procedures					E	F	G	H		J		
	From	To	POS	TOS		HCPCS	M1	M2	M3	M4				Pntr	Charge			Unit
1	[MM/DD/YYYY]	[MM/DD/YYYY]	[Dropdown]	[Dropdown]	[Dropdown]	[Dropdown]					1			[Dropdown]	[Dropdown]		[Icon]	[Checkbox]
2	[MM/DD/YYYY]	[MM/DD/YYYY]	[Dropdown]	[Dropdown]	[Dropdown]	[Dropdown]								[Dropdown]	[Dropdown]		[Icon]	[Checkbox]
3	[MM/DD/YYYY]	[MM/DD/YYYY]	[Dropdown]	[Dropdown]	[Dropdown]	[Dropdown]								[Dropdown]	[Dropdown]		[Icon]	[Checkbox]
4	[MM/DD/YYYY]	[MM/DD/YYYY]	[Dropdown]	[Dropdown]	[Dropdown]	[Dropdown]								[Dropdown]	[Dropdown]		[Icon]	[Checkbox]
5	[MM/DD/YYYY]	[MM/DD/YYYY]	[Dropdown]	[Dropdown]	[Dropdown]	[Dropdown]								[Dropdown]	[Dropdown]		[Icon]	[Checkbox]
6	[MM/DD/YYYY]	[MM/DD/YYYY]	[Dropdown]	[Dropdown]	[Dropdown]	[Dropdown]								[Dropdown]	[Dropdown]		[Icon]	[Checkbox]

Summary Fields:

- 28. Total Charge: [Text]
- 29. Amount Paid: [Text]
- 30. Balance Due: [Text]

Page Information:

TOTAL PAGES: 1 PAGE LIST: 1 [NEW PAGE/LAST PAGE](#) [Delete Line](#)

5 Enter Physician and Charge information into the applicable fields. The following field will be defaulted:

- Diagnosis Pointer = 1

6 Click the *Other Info > Ambulance* link if billing Transportation services.

The *Other Info > Ambulance* screen displays.

Screen 29 Other Info > Ambulance Screen

Patient & Subscriber | Service Lines | **Other Info** | Edit/Log | **Save** | **Exit**

General | **Ambulance** | DME | PT/Chiro | Functions | Printing

Claim Ambulance Transport Info

Patient Weight Lbs | Transport Code | Reason Code | Distance Miles

Round Trip Purpose | Stretcher Purpose

Vehicle License Number | Vehicle License State

Claim Ambulance Certification

N/A ☐ 01 Patient was admitted to a hospital | N/A ☐ 02 Patient was bed confined before the ambulance service

N/A ☐ 03 Patient was bed confined after the ambulance service | N/A ☐ 04 Patient was moved by stretcher

N/A ☐ 05 Patient was unconscious or in shock | N/A ☐ 06 Patient was transported in an emergency situation

N/A ☐ 07 Patient had to be physically restrained | N/A ☐ 08 Patient has visible hemorrhaging

N/A ☐ 09 Ambulance service was medically necessary | N/A ☐ 12 Patient is confined to a bed or chair

N/A ☐ 60 Transportation was to the nearest facility

Claim Ambulance Location Info

Pick-Up Address | City | State | Zip | Country

Drop-Off Address | City | State | Zip | Country

Location

Service Line Ambulance Transport Info/Certification

Procedures	Patient Weight (Lbs)	Transport Code	Reason Code	Distance (Miles)	Round Trip Purpose	Stretcher Purpose	Patient Count
1		<input type="text"/>	<input type="text"/>				

Yes/No | Certification Code | Yes/No | Certification Code

[Append More Ambulance Certification Lines...](#)

Service Line Ambulance Location Info

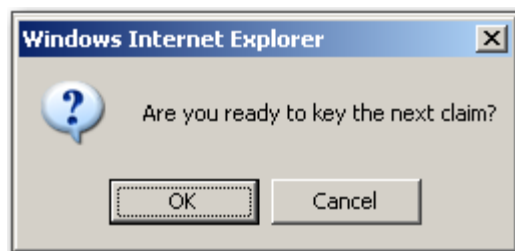
Pick-Up Address | City | State | Zip | Country

Drop-Off Address | City | State | Zip | Country

Location | Origin Time | Destination Time

- 7 Enter Transportation information into the applicable fields.
- 8 Click the **Save** button to save the claim.
- 9 Click the **Exit** button to leave the claim.

The following message displays.



10 Click **OK** to key the next claim. Click **Cancel** to leave the screen.

Creating and Printing Medicaid Illinois HFS Forms

Medicaid Illinois HFS claim forms and adjustment forms can be created on demand or in a batch as Adobe PDF files for printing to your local printer. The PDF file is formatted to print based on the option selected. For detailed descriptions of the printing setup options and Adobe requirements, see the "Printing and Viewing Claims" section of Chapter 5 of the *Claim Master Professional User Reference*.

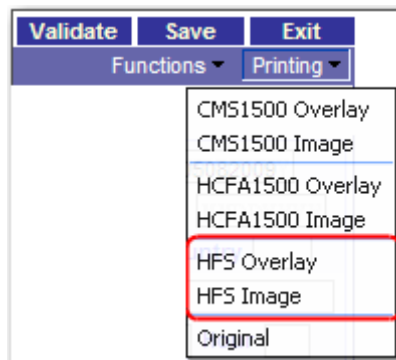
Client Setup Required



Access to the Medicaid Illinois HFS form specific fields and the capability to create the Medicaid Illinois HFS forms is a premium service that requires setup by the Emdeon Implementation Administrator.

On Demand Claim Forms

The Printing pull-down menu, which is located directly under the Exit button, displays the available on demand claim printing options for Claim Master. The **HFS Overlay** and **HFS Image** options are used to create the Medicaid Illinois HFS claim forms based upon the Type of Service (TOS) entered on the **Service Lines** > **Original Info** screen.



Selecting the **HFS Overlay** option will create the claim, with the form pre-formatted in red in the background, to print to white paper on your local printer.

Selecting the **HFS Image** option will create the claim, formatted with claim data only, to print on pre-printed forms on your local printer.



Note

Prior to printing any claim forms, you must verify that your printer is loaded with the correct forms or paper.

The Type of Service (TOS) entered on the **Service Lines > Original Info** screen in Claim Master determines the appropriate Medicaid Illinois HFS claim form to create.

Table 25 HFS Form Descriptions > Type of Service (TOS) Crosswalk

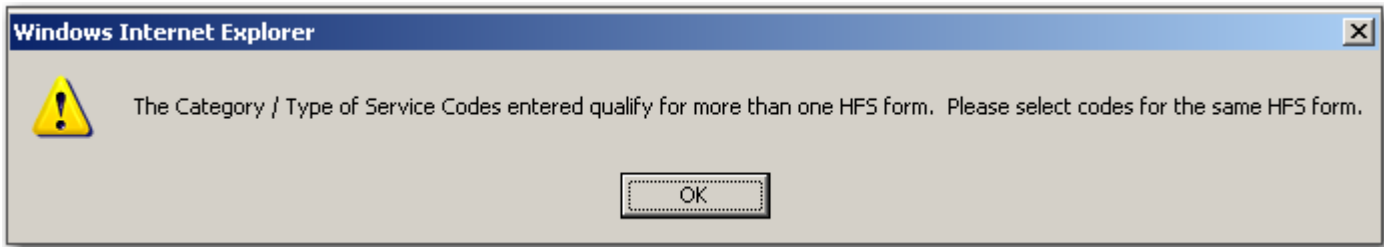
Number	Description	Type of Service (TOS)
1443	Provider Invoice (Therapy)	03, 04, 05, 11, 12, 13, 14, 33, 34, 45, 47
2209	Transportation Invoice	50, 51, 52, 53, 54, 55, 56
2210	Medical Equipment/Medical Supplies	41, 48
2360	Health Insurance Claim Form (Professional)	1, 2, 3, 4, 5, 7, 8, 9, G, S, Y

Selecting the **HFS Overlay** or **HFS Image** option without a Type of Service (TOS) entered will display the following message.



Click the **OK** button to return to the claim to enter a Type of Service (TOS) on the **Service Lines > Original Info** screen.

Selecting the **HFS Overlay** or **HFS Image** option with conflicting Type of Service (TOS) entered will display the following message.



Click the **OK** button to return to the claim to correct the Type of Service (TOS) entered on the **Service Lines > Original Info** screen.

On Demand Adjustment Forms

The Medicaid Illinois HFS adjustment form printing options are located on the **Service Lines > Adjustment** screen in Claim Master. The **HFS Adjustment > Print Overlay** and **HFS Adjustment > Print Image** options are used to create the Medicaid Illinois HFS 2292 adjustment form for each service line.

Main Menu > Search Claim > Edit Claim | Fri Jun 11 12:24:15 CDT 2010

Provider: QAE MEMORIAL HOSPITAL (436999977) Payer: MEDICAID IL (HEALTH FAMILY) (DSKIL000) P/S: P Status: Incomplete
 Patient: Patient Control #: TEST426017 0001 Claim #: 7957271
 From/Thru: 05/16/07 - 05/16/07 Lines: 1 Total Chg: \$68.80 Est Amt Due: \$68.80

23 Edit(s), 0 Fixed View All Edits << Previous Unfixed Edit < Previous Edit Next Edit > Next Unfixed Edit >>

Patient & Subscriber Service Lines Other Info Edit/Log Validate Save Exit

Original Lines | Adjustment Functions Printing

DOS From	DOS To	POS	TOS	HCPCS	M1	M2	M3	M4	Charge	Unit	Approved	OTAF
1	20070516	20070516	22	77080					68.80	1 UN		

HFS Adjustment Print Overlay Print Image

6. Voucher 7. Document Control Number 14. Adj Type 15. Item or Service

20. Reason Adjustment Requested: 16. Quantity 17. Charges 18. TPL 19. TPL Amt

Adjudication Payer -- PLEASE SELECT A PAYER -- Add Clear Adjudication Date Paid Amount

HCPCS M1 M2 M3 M4 Paid Units Bundled Line # Patient Liab

Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount	Group	Reason	Quantity	Amount
1				2				3			

28. Total Charge: 68.80 29. Amount Paid: 30. Balance Due: 68.80

Selecting the **HFS Adjustment > Print Overlay** option will create the adjustment form, with the form pre-formatted in red in the background, to print to white paper on your local printer.

Selecting the **HFS Adjustment > Print Image** option will create the adjustment form, formatted with claim data only, to print on pre-printed forms on your local printer.



Note

Prior to printing any claim forms, you must verify that your printer is loaded with the correct forms or paper.

Submitting Paper Claims

Claim Master provides the option to submit claims in a hardcopy or paper format in addition to electronically. Claims that are assigned to a 'Paper' Payer ID or Secondary claims that require a hardcopy EOB facsimile will have a Paper Medicaid Illinois HFS claim form created from the Submit Claim process. Paper Medicaid Illinois HFS claim forms can be created and formatted to print at your local printer via the FileBox, or to the Emdeon Clearinghouse via the Print Mail service.

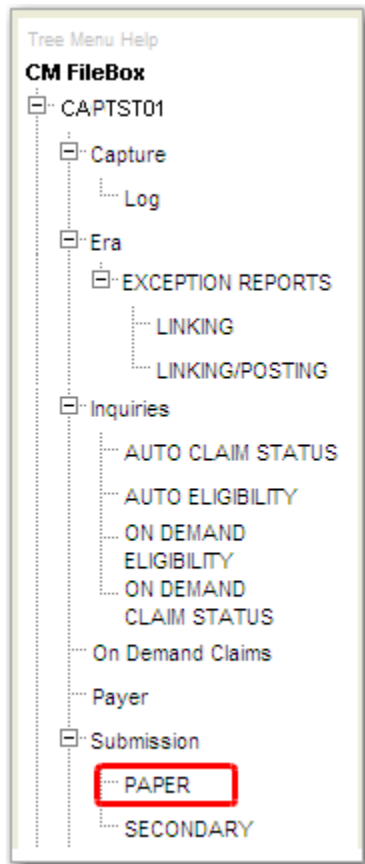


Client Setup Required

Print Mail is a premium service that requires setup by the Emdeon Implementation Administrator.

Primary HFS Claim Forms

For *Primary* Medicaid Illinois HFS claim forms that are directed to print to the FileBox, a batch file is created from the Submit Claim process. These claims are sorted by the Payer Name entered on the claim, Patient Last Name, and Patient Account #. They are formatted to print on blank Medicaid Illinois HFS claim forms, which must be placed in your printer tray. The printable claims can be found under the **Report Menu >Downloadable Reports From Filebox > Submission > Paper** folder.



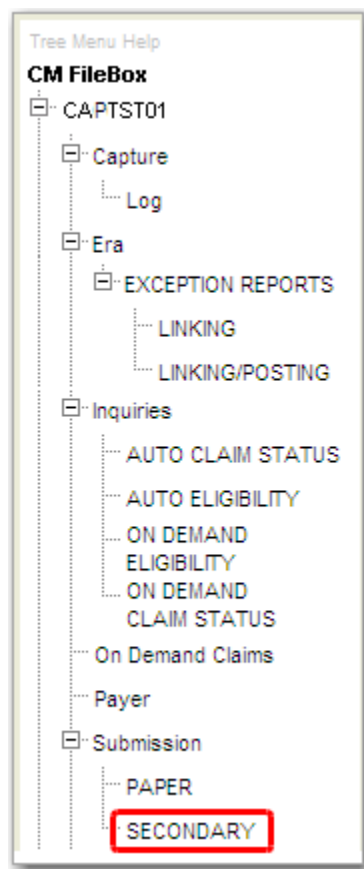
Separate print files are created for each type of Medicaid Illinois HFS claim form based upon the Type of Service (TOS) that was entered on the **Service Lines > Original Info** screen in Claim Master.

Batch Submission Paper Claims				
>> Submission >> PAPER				
File Name	File Size	File Date ▼	Description	Printed
HFSP1443_13032.PDF	4 Kb	2009-08-03 06:03:57	HFS 1443 Paper Form Print Spool: 13032-999366	<input type="checkbox"/>
HFSP2209_13032.PDF	2 Kb	2009-08-03 06:03:57	HFS 2209 Paper Form Print Spool: 13032-999366	<input type="checkbox"/>
HFSP2210_13032.PDF	2 Kb	2009-08-03 06:03:57	HFS 2210 Paper Form Print Spool: 13032-999366	<input type="checkbox"/>
HFSP2360_13032.PDF	5 Kb	2009-08-03 06:03:57	HFS 2360 Paper Form Print Spool: 13032-999366	<input type="checkbox"/>

To keep track of the files that have been printed, select the checkbox under the Printed column as you print each individual file.

Secondary HFS Claim Forms

For *Secondary* Medicaid Illinois HFS claim forms that are directed to print to the FileBox, a batch file is created from the Submit Claim process. These claims are sorted by the Payer Name entered on the claim, Patient Last Name, and Patient Account #. They are formatted to print on plain white paper, which must be placed in your printer tray. Secondary Paper claims in the Medicaid Illinois HFS format are pre-formatted with the red form background. Secondary Paper claims that have an ERA linked in Payment Manager are printed and collated with a facsimile of the paper EOB. The printable claims can be found under the **Report Menu > Downloadable Reports From Filebox > Submission > Secondary** folder.



Separate print files are created for each type of Medicaid Illinois HFS claim form based upon the Type of Service (TOS) that was entered on the **Service Lines > Original Info** screen in Claim Master.

Batch Submission Secondary Claims

>> Submission >> SECONDARY

File Name	File Size	File Date ▼	Description	Printed
HFSec2210_13032.PDF	293 Kb	2009-08-03 06:03:59	HFS 2210 Secondary Form Print Spool: 13032-999366	<input type="checkbox"/>
HFSec2360_13032.PDF	324 Kb	2009-08-03 06:03:59	HFS 2360 Secondary Form Print Spool: 13032-999366	<input type="checkbox"/>
HFSec1443_13032.PDF	341 Kb	2009-08-03 06:03:58	HFS 1443 Secondary Form Print Spool: 13032-999366	<input type="checkbox"/>
HFSec2209_13032.PDF	339 Kb	2009-08-03 06:03:58	HFS 2209 Secondary Form Print Spool: 13032-999366	<input type="checkbox"/>

To keep track of the files that have been printed, select the checkbox under the Printed column as you print each individual file.

