5

5 Filing Claims

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

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

This chapter provides basic information for filing claims. The information is not specific to provider type; it is intended to give all providers an understanding of the various methods for claims submission and instructions on completing claims forms. Once you understand the information in this section, you can refer to the chapter in Part II that corresponds to your provider type for additional claims filing information.

This chapter contains the following sections:

- *Before You Submit Your Claim,* which describes how claims are processed, which claim forms are approved for submission to Medicaid, and other general claim-related information
- *Completing the CMS-1500 Claim Form*, which provides detailed billing instructions for the CMS-1500 claim form
- *Completing the UB-92 Claim Form*, which provides detailed billing instructions for the UB-92 claim form
- *Completing the ADA Dental Claim Form*, which provides detailed billing instructions for the ADA Dental claim form
- *Completing the Pharmacy Claim Form*, which provides detailed billing instructions for the Pharmacy claim form
- *Crossover Claim Filing*, which provides billing instructions for the medical and institutional crossover claim forms. **Please note that Alabama Medicaid requires paper crossovers to be submitted using the approved Medical and Institutional Medicaid/Medicare-related crossover claim forms.**
- *Required Attachments*, which lists and describes the Alabama Medicaid required attachments
- *Adjustments,* which provides instructions for submitting online and paper adjustments. **Please note that Alabama Medicaid requires paper adjustments to be submitted on the approved Adjustment form.**
- *Refunds,* which provides instructions on receiving refunds
- *Inquiring about Claim and Payment Status,* which describes various methods for contacting EDS to inquire about claim and payment status

5.1 Before You Submit Your Claim

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

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

5.1.1 Valid Alabama Medicaid Claim Types

Alabama Medicaid processes eight different claim types (Managed Care claims are described in Chapter 39, Patient 1st). The claims can be submitted on paper or in electronic format. Alabama recognizes two standard claim forms (UB-92 and CMS-1500) and four Medicaid non-standard claim forms (Pharmacy, Dental, and two Medicare/Medicaid-related claim forms) for the submission of these claims. The provider's provider type determines which claim type to bill, as illustrated in the table below.

Claim Type	***Claim Form***	***HIPAA Transaction***	***Providers Who Bill Using This Claim Type***
Medical	CMS-1500	837 Professional	• Physicians • Physician Employed Practitioners (CRNP and PA) • Independent Labs • Independent Radiology • Transportation • Prosthetic Services • DME • Podiatrists • Chiropractors • Psychologists • Audiologists • Therapists (Physical, Speech, Occupational) • Optometrists/Opticians • Optical Dispensing Contractor • Clinics • Rural Health Clinics (IRHC, PBRHC) • FQHC • County Health Departments • Targeted Case Management • Independent Nurse Practitioner • Hearing Aid Dealer • Waiver Services (Homebound, Elderly and Disabled, MR/DD) • Maternity Care • State Rehab Services (Mental Health Centers, DYS, DHR) • CRNA • Nurse Midwife

Claim Type	*Claim Form*	*HIPAA Transaction*	*Providers Who Bill Using This Claim Type*
Dental	2002,2004 ADA	837 Dental	Dentists/Oral Surgeons when billing CDT codes
Pharmacy	XIX-BC-10-93	NCPDP	Pharmacists
Inpatient	UB-92	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient	UB-92	837 Institutional	• Hospitals • Ambulatory Surgical Centers (straight Medicaid) • Hemodialysis • Private Duty Nursing • Hospice Facility • Home Health Services • Lithotripsy (ESWL)
Medical crossover	Medical Medicare/Medicaid-Related Claim	837 Professional	All providers listed under the medical claim type • Ambulatory Surgical Centers (crossover claims) **Exceptions** (these provider types are not covered for Medicare-related claims): • Nurse Midwife • Targeted Case Management • Maternity Care • Waiver Services
Inpatient crossover	Institutional Medicare/Medicaid-Related Claim	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient crossover	Institutional Medicare/Medicaid-Related Claim	837 Institutional	• Hospitals • Dialysis • CORF (Comprehensive Outpatient Rehabilitation Facility) • Nursing Facility (Therapy) • Home Health Services

5.1.2 How Claims are Processed

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

Internal Control Number

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

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

Claims Processing

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

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

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

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

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

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

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

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the checkwriting schedule published in the *Provider Insider*, the Alabama Medicaid provider bulletin produced by EDS. The check is sent to the provider's payee address with an Explanation of Payment (EOP), which also identifies all denied claims, pending claims, and adjustments. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider. EOPs are described in Chapter 6, Receiving Reimbursement.

5.1.3 Methods for Submitting Claims

EDS accepts claims in electronic or paper format. Paper claims must be submitted using the approved claim formats listed in the table in Section 5.1.1, Valid Alabama Medicaid Claim Types.

To improve hard copy claims processing, EDS now scans paper claims and performs Optical Character Recognition (OCR) to enter data from the claims into the Medicaid system. All CMS-1500 and UB-92 paper claims must be submitted using red dropout forms. The scanner drops any red or blue markings on the claim form, leaving only the data the provider entered on the claim form.

NOTE:

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

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

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

Providers can obtain Medicaid/Medicare-related claim forms free of charge from EDS. Providers may purchase copies of CMS-1500 and Alabama Medicaid Pharmacy claim forms from EDS by writing or calling the EDS Provider Assistance Center:

EDS Provider Assistance Center
P.O. Box 244032
Montgomery, AL 36124-4032
1 (800) 688-7989

5.1.4 Electronic Claims Submission

Electronic claims may be submitted using a variety of methods:

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

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

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

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

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

5.1.5 Filing Limits and Approved Exceptions

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

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

- Claims filed in a timely manner with Medicare or other third party payers may be processed if received by the fiscal agent within 120 days of the third party disposition date. This date **must** be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider and a copy of the dated insurance must be attached to the claim. Providers should state the disposition date in the following format: "TPL-12-1-99" or "TPL-Dec. 1, 1999."

  Medicare EOMBs are no longer a required attachment, except as described above when the service is past the one year filing limit and within 120 days of the Medicare EOMB date. Providers must use the appropriate Medicare/Medicaid-related form (Institutional or Medical). Refer to Appendix E, Medicaid Forms, for a sample. Providers are reminded that claims that are denied by a third party payer must be submitted with a copy of the dated denial sheet attached. Third party payer denials must still be attached with the appropriate claim form or Medicare/Medicaid-related form.

- Claims for services rendered to a recipient, during a retroactive eligibility period, may be processed if received by the fiscal agent **within one year** from the date of the retroactive award. **Providers should indicate in Block 19 on the CMS-1500 claim form or in Block 84 on the UB-92 claim form the retroactive eligibility award date and submit a copy of the award notice with the claim(s).**

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

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

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

Claims for inpatient hospital services provided through Partnership Hospital Programs (PHP) must be filed by the last day of February for the previous year. For example, claims with dates of service 10-1-2002 through 9-30-2003 must be filed by 2-29-2004. Inpatient claims may not span calendar or fiscal years and must be split-billed.

NOTE:

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

5.1.6 Recipient Signatures

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

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

5.1.7 Provider Signatures

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

Medical Claims

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

Individual practitioners (not groups or clinics) may sign a medical claims submission agreement with Medicaid for the submission of paper claims instead of signing individual claim forms.

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

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

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

If an agreement is not signed, the individual practitioner must personally sign the claim form in the appropriate area or initial the claim form beside a typewritten or stamped signature. An individual practitioner's name or initials may be signed by another person who has power of attorney from the practitioner.

Tape Billers

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

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

Electronic Billers

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

Diskette Billers

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

Computer Generated Claim Forms

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

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

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

5.1.8 Submitting Paid and Partially Paid Claims to Medicaid

Providers may submit paid and partially paid third party claims to Medicaid using the approved paper or online filing methods as described in Chapter 5, Filing Claims. **The following third party-related information is required on the claim,** in addition to the other required claim data:

Claim Form	*Include the Following Third Party Information*	*In These Claim Fields*
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL paid dates • Amount paid	• Blocks 9-9d • Block 10 • Block 19 • Block 29
UB-92	• Other payer name • Prior payments • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL paid date	• Block 50 • Block 54 • Block 58 • Block 60 • Block 61 • Block 62 • Block 78 • Block 84
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#)/Policy Number • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code • Carrier Pays	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11 • Block 32 Other Fee(s)
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL payment	• TPL carrier information • TPL payment/denial information

NOTE:

Failure to list the third party payment in the appropriate space on the claim may cause the claim to deny.

If the claim is less than one year old, you may submit the claim electronically and Medicaid does not require the attachment of the third party Explanation of Payment (EOP). For claims more than one year old, you must submit the claim on paper and attach a copy of the third party EOP. You must submit claims more than one year old **within 120 days** of the third party payment.

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

- The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference will be paid to the provider.
- Third Party contractual write-offs or discounts should not be billed to Medicaid. Medicaid should be billed for the recipient's liability only. Any contractual write-off or discount covered by the primary insurance should be included in the amount designated as paid by the primary insurance on the claim to Medicaid.

- Third party paid amounts exceeding the Medicaid allowed amount will receive no further payment from Medicaid. Medicaid will place a zero paid amount on the claim and include an explanatory EOB code on the Explanation of Payment (EOP). **Patients cannot be billed under this condition.**

5.1.9 Submitting Denied Claims to Medicaid

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

Claim Form	***Include the Following Third Party Information***	***In These Claim Fields***
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL denied dates • Amount paid	• Blocks 9-9d • Block 10 • Block 19 • Block 29
UB-92	• Other payer name • Prior payments • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL denied date	• Block 50 • Block 54 • Block 58 • Block 60 • Block 61 • Block 62 • Block 78 • Block 84
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#) • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code • TPL Denial Date (with EOB ATTACHED)	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11 • Block 35 Remarks
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL denial	• TPL carrier information • TPL payment/denial information

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

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

NOTE:

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

5.2 Completing the CMS-1500 Claim Form

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

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

CMS-1500 Electronic Billing

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

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

CMS-1500 Claims Form Paper Billing

CMS-1500 forms may be purchased through EDS. Providers may also obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard CMS format using red dropout ink.

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

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Payee's nine-digit Medicaid provider number
- Rendering (performing) provider's nine-digit Medicaid provider number (on each line item)

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

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5.2.1 CMS-1500 Blank Claim Form

APPROVED QMB-0938-0008

☐☐☐ PICA

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last name, first Name, Middle Initial)

3. PATIENTS BIRTH DATE MM DD YY SEX M ☐ F ☐

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

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

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

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

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

b. AUTO ACCIDENT? PLACE (state) ☐ YES ☐ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d.

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

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

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E B LINE)
1. 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place Of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OF UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME , ADDRESS, ZIP CODE, & PHONE #
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) ***PLEASE PRINT OR TYPE*** FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500 CMS-1500-1 (Rev. 12-90)

SAMPLE

5.2.2 CMS-1500 Claim Filing Instructions

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

Block No.	*Description*	*Guidelines*
1a	Insured's ID no.	Enter the patient's 13-digit recipient number (12 digits plus the check digit) from the Medicaid identification card and/or eligibility verification response. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
2	Patient's name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID number you entered in Block 1.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
3	Patient's date of birth Patient's sex	Enter the month, day, and year (MM/DD/YY) the recipient was born. Indicate the recipient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (city, state, and ZIP code).
9-9d	Other insured's name	If the recipient has other health insurance coverage, enter all pertinent information. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid.**
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
17	Name of referring physician or other source	Enter one of the following, if applicable: • The name of the referring PMP provider • The EPSDT referring provider if the services are the result of an EPSDT screening • The referring lock-in physician if the eligibility verification response indicates the recipient has Lock-In status Please refer to Section 3.3, Understanding the Eligibility Response, for information on Lock-in or as they relate to recipient eligibility Appendix A, EPSDT, provides referral instructions for EPSDT.
17a	ID number of referring physician	Enter the nine-digit Medicaid provider number corresponding to the provider entered in Block 17, if applicable. Anesthesia providers must submit the UPIN number of the referring surgeon/physician.

Block No.	*Description*	*Guidelines*
19	Reserved for Local use	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • Home accident • Treatment due to disease • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date The substitute provider's name may also be indicated here.
21	Diagnosis or nature of illness or injury	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not include diagnosis descriptions. Do not use decimal points in the diagnosis code field.
23	Prior Authorization Number	If the service requires prior authorization, enter the ten-digit PA number provided on the prior authorization notice here. Do not include the PA notice with the claim. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type. **Do not use for any other number. Leave blank if this does not apply.**
24a	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If identical services (and charges) are performed on the same day, enter the same date of service in both "from" and "to" spaces, and enter the units perform in Block 24g. **Exception**: Provider visits to residents in nursing facilities must be billed showing one visit per line.
24b	Place of service (POS)	Enter a valid place of service (POS) code for each procedure. For program-specific POS values, refer to the chapter in Part II that corresponds to your provider or program type.
24c	Type of Service (TOS)	TOS is no longer a required field on the Medicaid claim form. The system automatically assigns TOS codes based on the procedure code billed.
24d	Procedures, Services, or Supplies CPT/HCPCS and MODIFIER	Enter the appropriate five-digit procedure code (and two-digit modifier, as applicable) for each procedure or service billed. Use the current CPT-4 book as a reference. Note: Up to 4 modifiers can be entered per procedure code.
24e	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to the primary ICD-9 code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis to which the procedure is related must be the one identified. Enter only one digit in this block.
24f	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24g	Units	Enter the appropriate number of units. Be sure that span-billed daily hospital visits equal the units in this block. Use whole numbers only.

Block No.	***Description***	***Guidelines***
24h	EPSDT Family Planning	Enter one of the following values, if applicable: • "1" if the procedure billed is a result of an EPSDT referral • "2" if the procedure is related to Family Planning • "3" if the procedure is a Patient 1st (PMP) referral Effective April 1, 2005 the referral requirement for Patient 1st recipients was reinstated. • "4" if the procedure is EPSDT and PMP referral
24I	EMG	This block is used to indicate certain copayment exemptions, or Patient 1st referral exemption for Certified Emergency. Enter an "E" for emergency or "P" for pregnancy, if applicable. Do not enter Y or N. Effective April 1, 2005 the referral requirement for Patient 1st recipients was reinstated.
24k	Reserved for local use	Enter the rendering (performing) provider's nine-digit Medicaid provider number. The rendering (performing) provider is the one who performs the service.
26	Patient account number	This field is optional. Up to 20 alphanumeric characters may be entered in this field. If entered, the number appears on the provider's Explanation of Payment (EOP) to assist in patient identification.
28	Total charge	Enter the sum of all charges entered in Block 24f lines 1-6.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**
30	Balance due	Subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	After reading the provider certification on the back of the claim form, sign the claim. In lieu of signing the claim form, you may sign a Medicaid Claims Submission Agreement, to be kept on file by EDS. The statement "Agreement on File" must be entered in this block. The provider or authorized representative must initial the provider's stamped, computer generated, or typed name.
33	Physician's or supplier's name, address, zip code, and telephone number PIN# GRP#	Enter the payee's name and address in the space provided. The payee name is printed in the upper right corner of the EOP. PIN# is not a required field. Do not enter PIN#. Enter the payee's nine-digit Medicaid provider number in the GRP# field. The payee number is the number printed in the upper left corner of the EOP. **NOTE: If the payee is a group or clinic, the rendering (performing) provider whose number is listed in Block 24k must be enrolled as a member of the group or clinic.**

5.3 Completing the UB-92 Claim Form

This section describes how to complete the UB-92 claim form for submission to EDS. For a list of providers who bill for services using the UB-92 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

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

UB-92 Electronic Billing

Electronic billers must submit UB-92/837 Institutional claims in approved formats. The 837 Institutional transaction allows providers to bill up to 999 details per Institutional (837 Institutional transaction) claim type. Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the EDS Electronic Claims Submission Help Desk at 1(800) 456-1242.

UB-92 Claims Form Paper Billing

EDS does not supply the UB-92 claim form. Providers may obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard UB-92 format using red dropout ink.

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

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's eight-character Medicaid provider number

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

5.3.1 UB-92 Blank Claim Form

APPROVED QMB NO. 0938-0279

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL

5. FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTH DATE | 15 SEX | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

50 PAYER | 51 PROVIDER NO. | 52 REL. INFO | 53 ASG. BEN | 54. PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT

58 INSURED'S NAME | 59 P.REL | 60 CERT.-SSN-HIC.-ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E | 83 OTHER PHYS. ID A | OTHER PHYS. ID B

84 REMARKS | 85 PROVIDER SIGNATURE X | 86 DATE

UB-92 HCFA-1450

TITLE POSITION

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

SAMPLE

5.4 UB-92 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the UB-92 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by EDS.**

Block No.	***Description***	***Guidelines***
1	Provider name, address, and telephone number	Enter the provider name, street address, city, state, ZIP code, and telephone number.
2	Referring Provider number	Enter the referring physician's provider number for the following types of referrals: • EPSDT referrals • Patient 1st referrals • Lock-in Physician referrals The referring provider number should contain nine digits. A condition code of A1 is only required if the referral number is an EPSDT referral. If not applicable, leave blank.
3	Patient control number	**Optional**: Enter your internal medical record number. This may be an alpha or numeric string (limit 20 characters). If entered, the number appears on the provider's Explanation of Payment (EOP) to assist in patient identification.

Block No.	***Description***	***Guidelines***
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice	Enter the three-digit type of bill (TOB) code: **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care 3 Home Health Agency 7 Clinic (RHC, FQHC) *** see note** 8 Special Facility **** see note** **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim ***Clinic requires one of the following as the 2nd Digit – Bill Classification:** 1 Rural Health 2 Hospital-Based or Independent Renal Dialysis Center 3 Free-Standing 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facility (CORF) 6-8 Reserved for National Assignment 9 Other ****Special Facility requires one of the following as the 2nd Digit – Bill Classification:** 1 Hospice (non-hospital-based) 2 Hospice (hospital-based) 3 Ambulatory Surgical Center 4 Free-Standing Birthing Center 5-8 Reserved for National Assignment 9 Other
6	Statement covers period	Enter the beginning and ending dates of service billed. For inpatient hospital claims, these are usually the date of admission and discharge.
7	Covered days	Enter the total days represented on this claim that are to be covered. This is not required for outpatient claims.
8	Non-covered days	Enter the total days represented on this claim that are not covered. This is not required for outpatient claims. **The sum of blocks 7 and 8 must equal the total days billed as reflected in block 46.**

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

Block No.	***Description***	***Guidelines***
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. Refer to the UB-92 Billing Manual for the valid patient status codes. If status code 30, the total days in blocks 7 and 8 should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
23	Medical record number	Enter the patient's medical record number assigned by the hospital. This number will be referenced on the provider's EOP for patient identification. Up to twenty numeric characters may be entered into this field.
24-30	Condition Codes	The following UB-92 condition codes are valid for EPSDT referral and/or PMP referrals: A1 Denotes services rendered as the result of an EPSDT screening. Block 2 must also contain the screening provider's 9-digit Medicaid provider number. A4 Denotes family planning and will exempt the claim from the $3 copay. If A1 is entered here, a referring provider number must be indicated in block 2.
32	Occurrence Codes	Accident related occurrence codes are required for diagnoses between 80000-99499.
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed. Refer to the UB-92 Uniform Billing Manual published by the Alabama Hospital Association for valid codes. Revenue 001 (Total) must appear on every claim.
44	HCPCS/Rates	Inpatient: Enter the accommodation rate per day. Home Health: Home Health agencies must have the appropriate HCPCS procedure code. Outpatient: Outpatient claims must have the appropriate HCPCS, procedure code.
45	Service date	Outpatient: Enter the date of service that the outpatient procedure was performed. Nursing Homes: Enter the beginning date of service for the revenue code being billed. Span Billing: When filing for services such as therapies, home health visits, dialysis, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator (FL) 6 (statement covers period). In FL 45, the service date should be the first date in the statement covers period. The number of units should match the number of services reflected in the medical record.
46	Units of service	Enter total number of units of service for outpatient and inpatient services. For inpatient claims, this will be same as covered plus non-covered days.
47	Total charges	Enter the total charges for each service provided.

Block No.	***Description***	***Guidelines***
48	Non-covered charges	Enter the portion of the total that is non-covered for each line item.
50	Payer	Enter the name identifying each payer organization from which the provider might accept some payment for the charges.
51	Medicaid no.	Enter the eight-character Medicaid provider number.
54	Prior payments	Enter any amounts paid by third party commercial insurance carrier(s). **Do not enter Medicaid copayment amount. Do not enter Medicare payment amount.**
58	Insured's name	If a third party carrier is involved, enter the insured's name.
60	Insurance identification number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response and the policy numbers for any other insurance on file. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
61	Insured group's name	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	Enter the group number of the other health insurance.
63	Treatment authorization code	Enter the ten-digit prior authorization number, if applicable. Do not include the PA notice with the claim. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type.
67	Principal diagnosis code	Enter the ICD-9 diagnosis code for the principal diagnosis to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.
68-75	Other diagnosis codes	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5) for each additional diagnosis. Do not use decimal points in the diagnosis code field. Enter one diagnosis per block.
76	Admitting diagnosis	Enter the admitting ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.
78	Medicaid emergency/accident indicator	Enter an "H" to indicate that the service was rendered as a result of a home accident or treatment due to disease. Enter "E" to indicate a certified emergency. Both values may be entered, as applicable. **A certified emergency ER claim must be certified by the attending physician.**
80-81 a,b,c,d,e	Principal and other procedure codes and dates	For inpatient hospital claims only, enter the ICD-9 procedure code for each surgical procedure and the date performed. Up to 5 surgical procedure codes and dates may be entered into this field.
82	Attending physician ID	Enter the attending physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
83 a,b	Other physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Blocks 80-81, enter the surgeon's license number.

Block No.	***Description***	***Guidelines***
84	Remarks	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date
85	Provider representative signature	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
86	Date bill submitted	Enter the date the bill was signed.

5.5 Completing the ADA Dental Form

This section describes how to complete the 2002, 2004 ADA Dental form for submission to EDS. For a list of providers who bill for services using the ADA Dental form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

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

Only version 2002, 2004 ADA Dental form is acceptable. If you experience problems with EDS processing your forms, contact EDS for resolution.

ADA Dental Electronic Billing

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

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

ADA Dental Claim Form Paper Billing

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

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

- Recipient's first and last name as it appears when verifying eligibility. NOTE: Recipient's Medicaid cards can have the name spelled differently that what is in our system.
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's nine-digit Medicaid provider number

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

NOTE:

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

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

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

5.5.1 ADA Dental Blank Claim Form

Please use the approved 2002, 2004 ADA Dental claim form printed using standard blue dropout ink.

5.5.2 ADA Dental Filing Instructions

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

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
2	Preauthorization Number	Enter the 10 digit Prior Authorization Number (if applicable)
4-11	Other Coverage/Other Insurance Information (These blocks are only required if patient has other insurance.)	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#) Enter the Other Insurance Policy Number • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code
12	Primary Insured Information (Medicaid Recipient Information)	Enter name as Last, First. Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you enter in Block 15.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe, A B" with no punctuation. For recipient D'Andre Doe, enter "Doe, D'Andre" with an apostrophe and no spaces.
15	Subscriber Identifier (SSN/ID#)/Medicaid Number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
24	Procedure Date/Date of Service (MM/DD/CCYY)	Enter numerically (MM/DD/YY) the date of service for each procedure provided.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
25	Area of the Oral Cavity/Oral Cavity Designation	If applicable, enter the Oral Cavity Designation Code associated with the procedure being performed on a specific tooth. 00 —Full Mouth 01 —Upper Arch 02 —Lower Arch 09 —Other Area of Oral Cavity 10 —Upper Right Quadrant 20 —Upper Left Quadrant 30 —Lower Left Quadrant 40 —Lower Right Quadrant L —Left R—Right There are few procedures that require an oral cavity designation. Some of these include D4341, D4355, D4910, D7970 and D7971.
27	Tooth Number or Letter	Enter the appropriate tooth number for permanent teeth (01-32) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. Enter AS – TS for children and 51-82 for adults for all supernumerary teeth regardless of location in maxilla or mandible. When spacers or partials are required, mark the missing teeth with an "X" on the claim form.
28	Tooth Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL). The block is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. M – Mesial F – Facial; Labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal B —Buccal; Labial
29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure(s) (such as D0120).
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
32	Other Fees	**Enter the amount paid by the other insurance or other third party sources known at the time of submission of the claim.**
33	Total Fee	Enter the total of the charges on the claim. **DO NOT SUBTRACT** the amount the other insurance pays (if applicable).
35	Remarks	The only information that should be written in this section is “TPL Denial Attached” and the date of the third party (other insurance) denial. Make sure the EOB denial statement is attached. NO OTHER comments should be written in this section.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
38	Place of Treatment	Enter the following place of service codes in the appropriate box: office, hospital, or other: • 11 – Dental office • 21 – Inpatient hospital • 22 – Outpatient hospital • 31 – Skilled Nursing facility *****Use the "HOSP" box to indicate outpatient hospital or inpatient hospital.**
45-47	Treatment Results From	As applicable, indicate yes or no. If yes, provide date of accident and state (if auto accident).
48	Billing Dentist or Dental Entity	Enter the billing provider's name, street, city, state, and ZIP code. The billing (payee) name, address, Medicaid number is printed in the upper left corner of the Explanation of Payments (EOP). This information must be entered exactly as it reads on the EOP.
49	Provider ID	Enter the provider number of the **actual** dentist performing the service. Enter the rendering (performing) provider's number. NOTE: If the billing provider (payee) entered in the License Number field at the bottom of the form is a group provider, the rendering (performing) provider must be a member of the group.
50	License Number	This space is for the billing (payee) provider number. Enter the billing provider's nine-digit Alabama Medicaid provider number in the license number field. The billing (payee) number is the number printed in the upper left corner of the Explanation of Payments (EOP). The rendering (performing) provider number and the billing provider number may or may not be the same, but each number **must** be entered in the appropriate location.
52	Phone Number	Enter the office phone number should Medicaid staff need to contact staff for questions/information.
53	Treating Dentist Information	Each claim form must have a provider signature, initials by a stamped signature or an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.6 Completing the Pharmacy Claim Form

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

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

Pharmacy Electronic Billing

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

Pharmacy Paper Billing

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

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

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's nine-digit Medicaid provider number
- Rx number (cannot be more than 7 digits)

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

5.6.1 Pharmacy Blank Claim Form

ALABAMA MEDICAID PHARMACY CLAIM XIX-DC-10-93

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

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

PHARMACY PROVIDER NO./NAME	DATE DISPENSED
PHARMACY ADDRESS	

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

PHARMACIST

	COPAY	PRIOR AUTHORIZATION NO.
1		
2		
3		

	G CODE					EFILL(S)			
	LA R NO.	PRODUCT DE	S.	N	QU TY	S PLY	TH	NO.	U AND CUSTOMARY / CENTS
2									
3									
								TOTAL	

	DOLLARS	CENTS	REASON CODE		DOLLARS	CENTS	REASON CODE		DOLLARS	CENTS	REASON CODE
1				2				3			

SAMPLE

5.6.2 Pharmacy Filing Instructions

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

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

Field Description	***Guidelines***
B/N	Brand Necessary. This field is also known as the "Dispense as Written (DAW)" field. Valid values are as follows: 0 No product selection indicated 1 Substitution not allowed by subscriber – Brand necessary 2 Substitution allowed – patient requested product dispensed 3 Substitution allowed – pharmacist selected product dispensed 4 Substitution allowed – generic drug not in stock 5 Substitution allowed – Brand drug dispensed as a generic 7 Substitution not allowed – Brand drug mandated by law 8 Substitution allowed – Generic drug not available in market place **Note: These "Dispense as Written" values are required for the DAW field for electronic pharmacy claims.**
Quantity	Enter the quantity or number of units dispensed. **Please note there are five (5) spaces on the claim form for quantity. All five spaces must be completed.** There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045. **If a product is supplied in fractional units (for instance, a 3.5gm tube of ointment), Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed. In this example, the quantity billed should be 0003.5**
Days supply	Enter the amount of time the medication dispensed should last. The days supply is limited to 34.
Refills	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.
Usual and customary	Enter the amount (dollars and cents) of your customary charge.
TPL payment/denial information	These fields are completed only if the recipient has other insurance. If the other insurance makes a payment, it should be indicated in the dollars/cents field. The appropriate NCPDP other coverage reason code must also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the NCPDP other coverage reason code must be included.

5.7 Crossover Claim Filing

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

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

5.7.1 Medical Medicaid/Medicare-related Claim Filing Instructions

For paper billing, the Medical Medicaid/Medicare-related claim form may be obtained from EDS at no charge. For scanning purposes, only those forms printed with red dropout ink will be accepted. Photocopies of this form will be returned.

A copy of the Medical Medicaid/Medicare-related claim form displays on the following page.

NOTE:

Providers must use the Medical Medicaid/Medicare-related claim form when billing Medicaid for Medicare Advantage plan copays. These claims will be processed by Medicaid in the same manner as a Medicare number in the HIC # field on the crossover claim rather than the Medicare Advantage Plan's assigned number. Medicare Advantage copays should be reported in the Medicare Coinsurance field.

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

Medical Medicaid/Medicare-related Blank Claim Form

Do not write in this space.

MEDICAL
MEDICAID/MEDICARE
RELATED CLAIM

Do not use red ink to complete this form.

RECIPIENT INFORMATION

Medicaid ID #	
First Name	
Last Name	
HIC #	
Patient Account #	

OTHER INSURANCE INFORMATION

Covered by other insurance? Enter Y if yes. (Except Medicare)	
Name of other insurance company (Except Medicare)	
Insurance company carrier code	
If payment was received from other insurance, post that amount here. (Do NOT put Medicare payment here.)	$

If other insurance rejected, attach rejection to completed claim and mail to EDS. *See Remarks.

Diagnosis Codes	1st DX		2ND DX		3RD DX		4TH DX	

Date of Service			Procedure				Medicare			
From	Thru	POS	Code	Mods	Units	Charges	Allowed	Coinsurance	Deductible	Paid
					TOTALS					

SAMPLE

Remarks

Enter IPL Denial (MMDDYY) in this block.

Performing Provider Number	
Performing Provider Name	

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

Submit completed claim to:

EDS
Post Office Box 244032
Montgomery, AL 36124-4032

Provider Mailing Address Required in block below.

Form 340 Revised 10/00

Alabama Medicaid Agency

Medical Medicaid/Medicare-related Claim Filing Instructions

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

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

Field Description	***Guidelines***
Medicaid ID #	Enter the recipient's 13-digit RID number.
First Name	Enter the recipient's first name.
Last Name	Enter the recipient's last name.
HIC#	Enter the recipient's Medicare HIC number.
Patient Account #	Enter recipient's patient account number (to be referenced on the EOP for patient identification). Up to 20 characters may be entered into this field.
Covered by other insurance?	Enter a "Y" here if recipient has a commercial insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other commercial insurance company (except Medicare).
Insurance company carrier code	Not used at this time.
If payment was received from other insurance, place that amount here.	Enter the amount the other insurance company paid in this block. Do not include Medicaid copayment amounts.
1st DX, 2nd DX, 3rd DX, 4th DX	Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.
Dates of service	Enter the from and through dates in MMDDYY format.
POS	Enter the two-digit place of service as filed to Medicare.
Procedure Code	Enter the five-digit procedure code.
Modifiers	Enter the modifiers for the procedure code. Enter up to 4 modifiers.
Units	Enter the number of units of service.
Charges	Enter the charge for each line item.
Allowed	Enter the Medicare allowed amount for each line item. *FQHC, PBRHC, and IRHC should enter the per diem encounter rate established by Medicaid for the facility for each line item.
Coinsurance	Enter the Medicare coinsurance amount for each line item. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**
Deductible	Enter the amount applied to the Medicare deductible for each line item.
Paid	Enter the Medicare paid amount for each line item. *FQHC, PBRHC, and IRHC should enter the Medicare per diem paid amount for each line item.
Totals	Total each column.
Rendering (performing) provider Number	Enter the rendering (performing) provider's nine-digit Medicaid provider number. Do not place any alpha characters in this block.
Rendering (performing) provider Name	Enter the rendering (performing) provider's name.
Provider Mailing Address	Enter the billing address, city, state, and zip code for the rendering (performing) provider.
Remarks	Enter TPL Paid/Denial Date (MMDDYY).

5.7.2 Institutional Medicaid/Medicare-related Claim Filing Instructions

For paper billing, the Institutional Medicaid/Medicare related claim form may be obtained from EDS at no charge. For scanning purposes, only those forms printed with red dropout ink will be accepted. Photocopies of this form will be returned. A copy of the Institutional Medicaid/Medicare-related claim form displays on the following page.

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

Institutional Medicaid/Medicare-related Blank Claim Form

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

INSTITUTIONAL MEDICAID/MEDICARE RELATED CLAIM

PROVIDER INFORMATION

Provider Number	
Provider Name	

BILL TYPE

RECIPIENT INFORMATION

Medicaid ID #	
First Name	
Last Name	
HIC #	
Patient Account #	

OTHER INSURANCE INFORMATION

Covered by other insurance? Enter Y if yes (Except Medicare)	
Name of other insurance company (Except Medicare)	
Insurance company carrier code	
If payment was received from other insurance, post that amount here. (Do NOT put Medicare payment here.)	$

If other insurance rejected, attach rejection to completed claim and mail to EDS.

ADMISSION

Date	Hour	Type	STAT

STATEMENT COVERS PERIOD *See Remarks.

From	Through	COV D	N C D	C I D	L R.D

Rev	PC/Rate	Mods	Units	DOS	Charges	Non-Cov
001				TOTALS		

ADMIT DX	
Principal DX	
Other DX	
Other DX	
Other DX	

Rema

* Enter T **denied (MM/DD/YY)** in this block

Total Medicare Paid Paid	Paid
Total Medicare Allowed	
Total Medicare Coinsurance	
Total Medicare Deductible	

SAMPLE

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

Send completed claim to:

EDS
Post Office Box 244032
Montgomery, AL 36124-4032

Provider Mailing Address Required in block below.

Form 341 Revised 10-00

Alabama Medicaid Agency

Institutional Medicaid/Medicare-related Claim Filing Instructions

This form is required for all medical Medicare-related claims in lieu of the UB-92 claim form and the Medicare EOMB. **The ONLY required attachments are for third party denials.** The Medicare EOMB is no longer required.

Provider Information

Provider Number	Enter the 8-character Medicaid provider number.
Provider Name	Enter the provider name.

Recipient Information

Medicaid ID #	Recipient's 13-digit Medicaid I.D. number
First Name	Recipient's First Name
Last Name	Recipient's Last Name
HIC #	Recipient's HIC I.D. number
Patient Account #	Recipient's patient account number. Up to 20 alphanumeric characters may be entered into this field.

Other Insurance Information

Covered by other insurance?	Enter a "Y" here if recipient has insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other insurance company (except Medicare).
Insurance company carrier code	Not used at this time
If payment was received from other insurance, place that amount here.	Place the amount the other insurance company paid in this block. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**

Admission and Statement Covers Period

Date	Enter date of admission
Hour	Enter hour of admission (in military time format)
Type	Enter type of admission
STAT	Enter patient discharge status
From and through dates	Enter from and through dates of service
COVD	Enter number of covered days
NCD	Enter number of non-covered days, if any
CID	Enter number of coinsurance days if applicable
LRD	Enter number of life time reserve days if applicable

Service Data

Rev	Enter the revenue codes for each line item.
PC/Rate	Enter the 5-digit procedure code or the accommodation rate for the line item.
Modifiers	Enter the 2-character if applicable. Enter up to 4 modifiers.
Units	Enter the number of units of service.
DOS	Enter the first date of service
Charges	Enter the total line item charge
Non-Cov	Enter the non-covered part of the line item charge if applicable
TOTALS	Enter the column totals.

Diagnosis Codes

ADMIT, Principal, Other, Other, Other	Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.

Remarks

Remarks	Enter the TPL Paid/Denied Date (MMDDYY)

Medicare Payment Information

Paid	Enter the amount Medicare paid on each line item.
Allowed	Enter the amount Medicare allowed on each line item.
Coinsurance	Enter the amount of Medicare coinsurance on each line item.
Deductible	Enter the amount of Medicare deductible on each line item.

Mailing Address

Provider mailing address	Enter the billing address for the rendering (performing) provider.

5.8 Required Attachments

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

Attachment	***Guidelines***
Third party denials other than Medicare	Providers must submit legible copies of third party denials when billing Medicaid services denied by a third party.

NOTE:

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

5.9 Required Consent Forms

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

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

5.10 Adjustments

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

5.10.1 Online Adjustments

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

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

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

Submitting Adjustments on Paper

Providers must use the Medicaid Adjustment Request form to submit paper adjustments. These forms can be ordered from EDS (see Appendix E). **This is the only approved form that will be accepted for paper adjustments.** The following instructions explain how this form should be completed.

NOTE:

Please do not attach a check with the Adjustment Request Form.

Completing the Adjustment Request Form

Section I - Provider Pay-to Information

Field Name	***Instructions for Completion***
Provider Number	Enter the Alabama Medicaid Provider Number under which payment is made.
Provider Name and Address	Complete this field with the same information used to bill Medicaid.

Section II- Paid Claims Information

Field Name	***Instructions for Completion***
ICN Number	Enter the 13-digit number exactly as it is printed on your EOP.
Recipient Number	Enter the 13-digit Medicaid identification number assigned to the recipient as it appears on your EOP.
Recipient Name	Enter the recipient's name exactly as it appears on your EOP.

Field Name	*Instructions for Completion*
Date(s) of Service	Enter the beginning and ending month, day and year of services rendered.
Billed Amount	Enter the exact amount you billed the Medicaid program for the services rendered.
Paid Amount	Enter the amount actually paid by Medicaid for services.

Section III- Reason for Recoupment or Adjustment

Field Name	*Instructions for Completion*
Description of Problem	Indicate the specific reason for the recoupment or adjustment request (from reasons listed on the form).
Signature, date, and telephone number	Enter the signature of the requestor, the date the request was prepared and the requestor's telephone number.

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

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

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

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

NOTE:

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

5.11 Refunds

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

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

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

Please provide the following information in the appropriate fields on the Check Refund Request exactly as it appears on your Explanation of Payment (EOP) for each refund you send to EDS:

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

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

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

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

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

5.12 Inquiring about Claim and Payment Status

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

- Call AVRS Provider Electronic Solutions Software
- Review the Explanation of Payment (EOP) for the corresponding checkwrite
- Contact the EDS Provider Assistance Center at 1(800) 688-7989
- Contact EDS Provider Relations in writing at **EDS Attn: Provider Relations P.O. Box 241685 Montgomery, AL 36124-1685.**
- Access the Alabama Medicaid Agency Interactive Services Website at https://almedicalprogram.alabama-medicaid.com/secure.

Calling AVRS

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

Contacting the EDS Provider Assistance Center

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

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

Contacting EDS in Writing

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

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

Accessing the Alabama Medicaid Agency Interactive Services Website

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

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

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