

Chapter Five

Claims Submission and Billing

Overview

Introduction This chapter provides information and instruction on the process of submitting Medicaid claims.

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Third Party Payers

Third Party Payment Guidelines

Federal regulations require Medicaid to be the “payer of last resort.” This means that all third parties including Medicare, TRICARE, Workers Compensation liability carriers, and private health insurance carriers must pay before Medicaid pays. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

Medicaid-Allowed Amount

If the Medicaid-allowed amount is more than the third party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay an additional amount.

Exceptions

Certain Medicaid programs are not considered “primary payers” regarding the payer of last resort provision. When a Medicaid recipient is entitled to one or more of the following programs or services, Medicaid pays first:

- ?? Vocational Rehabilitation Services
 - ?? Division of Health Services of the Blind
 - ?? Division of Health Services “Purchase of Care” Programs:
 - ?? Cancer program
 - ?? Prenatal program
 - ?? Sickle Cell program
 - ?? Crippled Children’s program
 - ?? Kidney program
 - ?? School Health Fund
 - ?? Tuberculosis program
 - ?? Maternal and Child Health Delivery Funds
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Medicaid Dual Eligibles

Medicaid pays Part B and Part A premiums for all Medicaid recipients who are not entitled to “free” Part A, and Part B premiums.

No Part A or Part A benefits exhausted: When a provider files charges under Part B where no Part A coverage exists, Medicare automatically crosses over that claim to Medicaid for the deductible and coinsurance amounts. Because no Part A coverage exists, the provider may file a straight claim to Medicaid for the charges, which are paid on a diagnosis -related group (DRG). Medicaid reimburses for claims using the DRG payment methodology. The DRG payment includes ancillary charges. When Medicare crosses a claim over for ancillary charges, **AND** Medicaid pays the coinsurance and deductible, a duplicate payment occurs. The payment for the coinsurance and deductible must be refunded.

All other Part B charges: File only the Medicare claim to Part B as a crossover and **DO NOT FILE A STRAIGHT CLAIM TO Medicaid** indicating the Medicare payment. Medicaid will pay the coinsurance on the Part B crossover; this is the only amount Medicaid owes. Filing a straight claim to Medicaid indicating the amount of Medicare payment results in a duplicate payment by Medicaid.

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Third Party Payers, Continued

Medicare - Covered Services

Medicaid denies claims for those recipients age 65 and older who are entitled to Medicare benefits but do not apply for Medicare. The provider may bill the recipient for Medicare covered services under these circumstances.

Noncompliance Denials

Effective December 1, 1997, state and federal Third Party Liability (TPL) laws mandate that Medicaid not pay for services denied by private health plans due to noncompliance with those plan requirements. If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay the service.

If the recipient has a private plan and does not inform the provider of such plan, and if the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services, if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the services. If, however, the recipient does present the private payer information to the provider and that provider knows that he or she is not a participating provider in the plan or cannot meet any other of the private plan requirements, the provider must inform the recipient of such and also tell the recipient that he or she will be responsible for payment of services.

Common noncompliance denials include failure to get a referral from a primary care physician, failure to go to a nonparticipating provider, failure to acquire a second opinion, failure to acquire preapproval, etc.

Discounted Fee-For-Service Payments

The Medicaid program makes payment to providers on behalf of recipients for medical services rendered but Medicaid is not an "insurer." Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient's private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount that the provider has agreed to accept as payment in full from the private plan.

Capitated Payments

When a provider accepts a capitated payment from a private plan and bills Medicaid for any balance, the provider must **bill only the copayment amount** due from the recipient. **Do not bill Medicaid the full charges**, even with the capitated amount indicated as an insurance payment. Medicaid is not responsible for any amount in excess of that amount for which the recipient is responsible.

Third Party Liability

How To Know if Third Party Liability Exists

The following suggestions help determine if a Medicaid recipient has third party liability:

1. Recipient’s Medicaid Identification (MID) card lists in the Insurance Data block up to three health or accident insurance policies and Medicare Part A or Part B applicable to the recipient. Insurance information on the card will include:
 - ?? insurance company name (by code)
 - ?? insurance policy number
 - ?? insurance type (by code)
 - ?? recipient covered by policy
2. When services are rendered, providers should ask the recipient if he has any additional health insurance coverage or other TPL. If health insurance is indicated, the provider bills the carrier before billing Medicaid. Before filing a claim with Medicaid, the insurance company must pay the claim or issue a written denial to the provider.
3. Provider Remittance Advice – when a claim is denied for other insurance coverage (EOB 94), the provider of service will receive a Remittance Advice (RA) indicating the other insurance company (by code), the policyholder name, and the certificate or policy number.

An “Insurance Company Code Book” can be obtained from Third Party Recovery (TPR) at the Division of Medical Assistance (DMA) upon request. The code book lists the two-digit “key” for the types of insurance coverage listed on the MID card.

What to Do If The Insurance Company Does Not Provide Written Denial

If the provider is unable to get a written denial from an insurance company or other third party payer, that provider can attach a completed Health Insurance Information Referral (DMA-2057) form to the claim indicating the name and telephone number of the individual verifying the third party denial. Also attach a DMA-2057 when:

- ?? Insurance coverage has lapsed.
- ?? The recipient has an insurance policy not listed on the MID card.

Send the Health Insurance Information Referral form attached to a copy of the claim to the TPR unit at DMA. (Refer to Appendix B for addresses and information on obtaining forms. See Attachment A for a copy of the form.)

Time-Limit Overrides on Third Party Liability

All Medicaid claims must be received by EDS within 365 days from the date of or within 180 days from a third party denial or partial payment in order to be accepted for processing and payment. Faxed claim copies are not accepted. Override of the time limit will be granted if the claim is filed within 180 days of the third party denial, **provided the claim was filed with the third party within the 365-day time period and within 18 months of date of the last RA.**

All requests for time-limit overrides due to the third party not responding within the Medicaid time limit must be addressed to the TPR unit at DMA. Include documentation of timely filing with the request.

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Third Party Liability, Continued

Refunds to Medicaid

When a provider does not learn of other health insurance coverage for a recipient until after receipt of Medicaid payment, the provider must:

1. File a claim with the health insurance company.
2. Upon receipt of payment, refund Medicaid the insurance payment or the Medicaid payment in full, whichever is less.
3. The provider may keep the larger payment.

Unless DMA requests in writing that refunds be sent to another address, provider refunds are sent to EDS.

One of the functions of the TPR unit is to ensure that Medicaid is the payer of last resort. When a recipient is identified as having other insurance coverage, TPR forwards a letter to the provider of service. The provider will be asked to file insurance for the dates of service listed and to refund the insurance payment or the Medicaid payment, whichever is less, to the Post Payment area of the TPR unit.

If the provider did not receive payment from the insurance carrier because the claim was rejected or denied, then the provider must send a copy of the Explanation of Benefits (EOB) in the response to TPR. If there is no response in 60 days from the date of the letter, TPR will request EDS to recoup this money for the specific date of service from the providers next check write.

Personal Injury Cases

Tort (Personal Injury) Liability

Medicaid recipients may qualify for other third party reimbursements because of an accident, illness, or disability. A third party, other than those already cited, may be legally liable. Frequently these injuries and illnesses result from automobile accidents or on-the-job injuries or illnesses not covered by Workers' Compensation.

North Carolina General Statute §108A-57 allows the State subrogation rights (i.e., the State has the right to recover any Medicaid payments from personal injury settlement awards).

Provider Rights in Personal Injury Cases

When a provider learns that a Medicaid recipient has been involved in an accident, the provider **must** notify the TPR unit. If the provider has knowledge of the accident at the time of filing the claim, a Recovery Accident Information report (DMA-2043) must be submitted with the claim. A DMA-2043 must also be submitted when anyone requests a copy of the bill. (See Attachment B for a copy of the Recovery Accident Information form.)

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Personal Injury Cases, Continued

Provider Rights in Personal Injury Cases
(continued)

The following information is required by TPR to pursue a case, and will assist the provider when filing a claim with the liability carrier:

- ?? name of insurance company
- ?? name of insured person responsible
- ?? insurance policy number
- ?? name and address of the attorney, if any

Note: A copy of a letter sent by an attorney or insurance carrier to the provider requesting information will suffice in lieu of the DMA-2043.

Deciding Who to Bill

The provider must choose between billing Medicaid and billing the liability carrier. A casualty claim **cannot** initially be filed with Medicaid, receive payment, and then bill the liability carrier (or the recipient) for the same service, even if the provider refunds Medicaid.

The provider cannot bill the recipient, Medicaid, or the liability carrier for the difference between the amount Medicaid paid and the provider's full charges. (See *Evanston Hospital V. Hauck*, 1 F.3d 540 [7th Cir. 1993])

Billing Medicaid

If the provider withholds billing Medicaid, the provider has six months from the date of a denial letter or receipt of payment from the insurance company or an to file with Medicaid, even where it is in excess of the 365-day filing deadline.

The following requirements must be met:

- ?? The provider must file a claim with the third party carrier or attorney within 365 days from the date of service.
- ?? The provider makes a bona fide and timely effort to recover reimbursement from the third party.
- ?? The provider submits documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial.

When Medicaid payment is received the provider is **paid in full** and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, it alone has the right to seek reimbursement for payment of service.

If the provider withholds billing Medicaid and receives a liability payment, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment.

Receiving Payment From a Liability Carrier

Providers may receive liability payments when the providers have not pursued or sought third party reimbursement. The provider may not keep any liability payment in excess of Medicaid's payment. Pursuant to federal regulations and the *Evanston* case, there is a distinction between private health insurance payments and other liable third party payments.

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Personal Injury Cases, Continued

Receiving Payment From a Liability Carrier
(continued)

If Medicaid discovers that a provider received Medicaid payment and communicates with a third party payer or attorney in an attempt to receive payment of any balance, Medicaid will recoup its payment to that provider immediately, regardless of whether the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	\$100.00
Amount paid by Medicaid	\$50.00
Amount paid by attorney/liability carrier	\$100.00
Amount to be refunded to Medicaid	\$50.00
Amount to be refunded to attorney/liability	\$50.00

Billing the Medicaid Recipient

The Initial Decision

Whether a provider can bill the recipient at any time depends upon how the provider accepted the recipient as a patient. The provider must make the decision initially to accept the patient as a Medicaid patient **before** rendering the service. **This decision is irreversible.**

Accepting the Recipient as a Medicaid Patient

When the provider initially accepts a recipient’s MID card upon rendering services, the provider accepts the recipient as a Medicaid patient, thereby accepting Medicaid’s payment as payment in full. If the provider accepts the recipient as a Medicaid patient, the provider may never bill the patient for that service. This is true even where the provider withholds billing Medicaid to seek full reimbursement from a liability carrier. If the provider withholds billing Medicaid and fails to receive sufficient reimbursement from the third party carrier, the provider’s only option is to file a claim with Medicaid indicating the liability payment, if any, on the claim.

If the recipient refuses to cooperate with the provider (by assisting or providing information where necessary) in seeking reimbursement from the third party carrier, the provider may bill the recipient for the full charges until recipient complies with needed information. (42 CFR §433.147)

Refusing the Recipient as a Medicaid Patient

The provider may initially refuse to accept the recipient’s MID card upon rendering services. The provider **must** make it clear to the recipient that he is being accepted as a private pay patient only and that the recipient will be personally responsible for the services.

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Billing the Medicaid Recipient, Continued

Refusing the Recipient as a Medicaid Patient (continued)

When accepting the recipient as a private pay patient the provider may bill the recipient for the full charges. If the provider does not receive sufficient reimbursement from a liability carrier, the provider may bill the recipient for the balance. The provider may use whatever legal means available to collect the debt. This includes receiving a pro-rata share of the one-third available per statute for the reimbursement of medical expenses and attempting to recover any remaining balance from the recipient's one-third recovery amount, not to exceed 50 percent of the net settlement amount exclusive of attorney fees.

Requesting a Copy of the Bill

When the recipient or other authorized agent requests a copy of the bill, the words "**MEDICAID RECIPIENT, BENEFITS ASSIGNED**" must appear in large, bold print on all copies of all bills which were or will be submitted to Medicaid. If a provider fails to comply with this requirement, Medicaid may recoup the amount it paid for each claim which failed to comply regardless of whether the provider receives payment or not from the third party.

If the provider chooses not to submit a bill to Medicaid initially the provider must put the words "**MEDICAID RECIPIENT**" on the bill because:

1. The provider may decide to file with Medicaid after giving out a copy of the bill.
 2. This language will put attorneys and insurance companies on notice that the patient is Medicaid.
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Health Insurance Premium Payment

DMA Payment of Health Insurance Premiums

DMA may pay health insurance premiums for Medicaid recipients when it is cost effective to do so. Cost effectiveness is determined when the cost of the premium, deductible, and coinsurance is less than the anticipated Medicaid expenditures.

The Health Insurance Premium Payment (HIPP) program is most cost effective for Medicaid recipients with catastrophic illnesses such as end stage renal disease, chronic heart problems, congenital birth defects, cancer, or AIDS. For any such recipient who will lose private health insurance coverage due to nonpayment of premiums, Medicaid will determine the cost effectiveness of paying these private health insurance premiums.

Eligibility for DMA Payment of Premiums

To be eligible for Medicaid payment of premiums, the recipient must be authorized for Medicaid and have access to private health insurance. (In most cases it will be through an employer.) DMA will pay the premiums only on existing policies or those known to be available to the recipient (e.g., through COBRA). Premiums will be paid for a family coverage policy when the policy is cost effective and it is the only way the recipient can be covered. Family members who are not eligible for Medicaid will not receive Medicaid payment for deductible, coinsurance, or cost-sharing obligations.

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Health Insurance Premium Payment, Continued

HIPP Eligibility Process

Medicaid reviews each recipient's case that meets any of the conditions cited above for possible premium payment. DMA verifies the insurance information, obtains premium amounts, makes the cost effectiveness determination, and notifies the recipient and the appropriate referral source.

When DMA determines that a group health insurance plan available to the recipient through an employer is cost effective, and the recipient is approved for participation in the HIPP program, the recipient is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the recipient voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer. However, if it is determined that a non-group health plan is cost effective, DMA will pay the cost of the premium, coinsurance, and deductible of such a plan if the recipient chooses to participate.

HIPP Information Availability

Information about HIPP is available through the local county department of social services (DSS) office. Brochures and applicable forms are also available in the local health departments, hospitals, hospices, rural health clinics, and Federally Qualified Health Centers (FQHC).

Commonly Asked Questions

1. **Q:** What is TPL, and how does it apply to me?

A: TPL is when another individual or company is responsible for paying medical services. Most commonly, these third parties are private health insurance and auto or other liability carriers. There are both state and federal laws, rules, and regulations setting out TPL requirements, which require these responsible third parties to pay for medical services prior to Medicaid. The TPR Unit at DMA is responsible for implementing and enforcing these TPL laws. The TPR unit implements and enforces these laws through both cost avoidance and recovery methods. Therefore, you are required to seek payment from these third parties when you know of their existence prior to seeking payment from Medicaid.

2. **Q:** When do I file my claim to EDS vs. TPR?

A: File your claim directly to EDS when (a) the recipient has no private health insurance, (b) the insurance EOB reflects an insurance payment, and (c) there is an insurance denial with the following reasons: applied to deductible; benefits exhausted; noncovered services (meaning the service was not and will never be covered under this policy; pre-existing condition and Medicare/Medicaid dually eligible with no private health insurance.

File your claim to TPR if the claim includes either a DMA-2057 (Health Insurance Information Referral Form), or an insurance EOB indicating any other type of denial not mentioned in (a) above

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Commonly Asked Questions, Continued

3. **Q:** Why did my claim deny for EOB 094 "Refile indicating insurance payment or attach denial?"

A: EDS/DMA's database indicates the recipient had third party insurance on the date of service for which you are requesting reimbursement. Our records show this type of insurance should cover the diagnosis submitted for payment. If your service could be covered by the type of insurance indicated, you **must** file a claim with that insurance company prior to billing the Medicaid program. If you receive a denial that does not indicate noncompliance with the insurance plan, or payment for less than your charges, bill the Medicaid program and, if appropriate, your claim will be processed and if the Medicaid allowable amount is greater than the insurance payment you received, Medicaid will pay the difference. It is the provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

If the insurance plan denied payment due to noncompliance with the plan's requirements, Medicaid will not make any payment on the claim.

If the insurance data was not indicated on the MID card, it was entered on the database after the MID card was printed and should be on the next MID card. You may also find this insurance information on your denial RA. **Note:** This denial does not refer to Medicare.

4. **Q:** If the Medicaid recipient is required to pay a copayment amount by their private insurance, can this amount be collected up front at the time the services are rendered?

A: No. The provider cannot bill the Medicaid recipient for the copayment amount unless the Medicaid payment is denied because the service was a noncovered service, and only then if the provider has advised the recipient in advance that the services are not covered.

5. **Q:** How do I determine the name of the third party insurance company that is indicated on the recipient's MID card?

A: An Insurance Code Book is available upon request from the TPR unit at DMA. This code book provides the name and billing address for each code that is listed on the MID card in the Insurance Data block under the subheading "Name Code." (Refer to Appendix B for information on obtaining a Code Book.)

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Commonly Asked Questions, Continued

6. Q: How do I determine what type of insurance the recipient has?

A: The blue and pink MID cards list an insurance name code, policy number, and type of insurance code. The buff MID card lists the insurance name code only. The insurance type codes are listed below. This is a key to be used by the providers in identifying third party resources as shown by the code on the MID card in the insurance data block under the subheading "Type."

<u>Code</u>	<u>Description</u>	<u>Code</u>	<u>Description</u>
00	Major Medical Coverage	09	Code No Longer Valid
01	Basic Hospital w/Surgical Coverage	10	Major Medical and Dental Coverage
02	Basic Hospital Coverage Only	11	Major Medical and Nursing Home
03	Dental Coverage Only	12	Intensive Care Coverage Only
04	Cancer Coverage Only	13	Hospital Outpatient Coverage Only
05	Accident Coverage Only	14	Physician Coverage Only
06	Indemnity Coverage Only	15	Heart Attack Coverage Only
07	Nursing Home Coverage Only	16	Prescription Drugs Coverage Only
08	Basic Medicare Supplement	17	Vision Care Coverage Only

7. Q: What do I do when my claim denies for EOB 094 and no insurance is indicated on the MID card?

A: Refer to the RA that showed the claim denying for EOB 094. The insurance information, the policyholder's name, certification number, and a three digit insurance code are listed below the recipient's name. The TPR unit furnishes a third party insurance code list to providers upon request.

8. Q: What is considered an acceptable denial from an insurance company?

A: An acceptable denial is a letter on company letterhead or an EOB from the insurance company or group/employers that also complies with the private plan's requirements.

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to the Provider Services Unit at EDS. (Refer to Appendix B for addresses.)

9. Q: Why did my claim deny for TPL after I included an insurance denial as referred to in question # 8?

A: Due to changes in the interpretation of federal laws, Medicaid denies payment for any service which could have been paid for by a private plan had the recipient or provider complied with the private plan's requirements. Examples of common private plan noncompliance denials include: failure to get referral from a primary care physician; nonparticipating provider; failure to acquire a second opinion; failure to acquire preapproval, etc. In these circumstances, the provider may bill the recipient for these services provided the noncompliance was not due to provider error, and/or appeal to the private plan.

It may be the provider's responsibility to secure such things as preapproval, referral from a primary care physician or to fulfill other requirements of the private plans.

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Commonly Asked Questions, Continued

10. Q: What are the uses of the DMA-2057 form (Health Insurance Information Referral Form) and where do I obtain copies?

A: The DMA-2057 form should be completed in the following instances:

- ?? When a written denial is unattainable;
- ?? To delete insurance information (e.g., a recipient has third party insurance that is not indicated on the MID card);
- ?? To add insurance information (i.e., a recipient has third party insurance that is not indicated on the MID card);
- ?? To change existing information (e.g., a recipient no longer has Major Medical third party coverage that has been terminated, or insurance company no longer exists, or change the type code, for example: TO CHANGE MAJOR MEDICAL CODE TO HOSPITAL ONLY).

(Refer to Appendix B for information on obtaining forms.)

11. Q: If the Medicaid recipient's private health insurance company pays the recipient directly, what may I bill the recipient?

A: If the amount of the insurance payment is known, you may bill the recipient for that amount only. You may also file your claim to Medicaid indicating the third party payment amount in the proper block on your claim form and Medicaid will pay the Medicaid allowable amount, less the insurance payment. If the insurance payment is unknown, you may bill the patient the total charges until the payment amount is known.

12. Q: May I have an office policy stating I will not accept Medicaid in conjunction with a private insurance policy?

A: Yes. A provider can refuse to accept Medicaid for recipients who also have third party coverage, even though they accept Medicaid for recipients who do not have third party coverage. However, providers must advise the recipient of their responsibility for payment before the services are rendered. The provider must obtain proper consent from the recipient of this arrangement.

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Commonly Asked Questions, Continued

13. Q: What do I do when a recipient, or other authorized person, requests a copy of a bill that I submitted to Medicaid?

A: If you have submitted the claim to Medicaid already, whether you have received payment yet or not, and if you have the proper patient authorization, you may provide a copy of the bill to the recipient, an insurance company, an attorney, or other authorized person, **ONLY IF** you comply with the following requirement. All copies of any bill which has been submitted to Medicaid **MUST** state “**MEDICAID RECIPIENT, BENEFITS ASSIGNED**” in large, bold print on the bill. If you provide a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

14. Q: How do I determine the amount of refund due Medicaid when Medicaid pays my claim and I receive payment subsequently from a third party liability carrier?

A: Once you have filed a claim with Medicaid and have received payment, your claim has been paid in full. Upon receipt of payment from the third party liability carrier, you must refund to Medicaid the amount of Medicaid’s payment and you must also refund to the patient or the liability carrier any remaining amount. By billing Medicaid and receiving payment, the provider relinquishes any right upon Medicaid’s payment for that service through assignment and subrogation. This includes the prohibition on the provider billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider’s full charges. This practice violates both state and federal laws.

However, the provider has the option to defer billing Medicaid and instead pursue a claim for full charges with the liability carrier. But, as long as the provider has filed a claim with the liability carrier within one year from date of service, and is diligently pursuing reimbursement from that liability carrier, the provider may file a claim with Medicaid within 180 days of a denial or payment from that carrier, even though it may be greater than the 12-month time limit for filing with Medicaid.

15. Q: How should I file my Medicare Part B crossover claim when a recipient is covered by a third party insurance company?

A: If a telephone denial is received from the third party company, a copy of the DMA-2057 form should be completed and attached to the claim and Medicare voucher. These should be sent to the TPR unit at DMA.

If a written denial is received from the third party company, a copy of this denial (including the explanation of denial code), claim copy, and Medicare voucher should be sent to the Provider Services Unit at EDS. (Refer to Appendix B for addresses.)

Claim Submission

General Information

Claims may be submitted by paper or electronically.

Complete all required form locators (form blocks) as directed in the billing section of this manual.

Recipient Has Medicare

Medicare claims cross over automatically to Medicaid if the provider's Medicare number is cross-referenced to their North Carolina Medicaid provider number in Medicaid's cross-reference files.

Medicare - Medicaid Reimbursement Procedure

If Medicaid was billed when Medicare should have been:

- ?? The TPR unit at DMA recoups the entire Medicaid payment by sending an adjustment form to EDS and notified the provider.
- ?? Notification letter itemized the recipient's name and MID number, the referenced dates of service, the Medicare health insurance claim (HIC) number, the Medicare entitlement date, medical record numbers – if applicable – and the total amount of the adjustment.

Do not send a refund check to Medicaid upon receipt of the letter. File the claim with Medicare, and if the provider's Medicare number is cross-referenced to their Medicaid provider number, the claim will automatically cross over.

Recipient Has Other Coverage

If recipient has other forms of insurance, show payment in block 29 of the HCFA-1500 form or attach voucher showing payment.

Electronic Claim Submission

Electronic Claim Submission (ECS) is the process of submitting claims through electronic media. Claims are processed through modem, magnetic tape, and diskette formats. A provider agreement must be completed and returned to DMA before billing electronically.

Software is available through the ECS Unit at EDS. Before using software from a vendor, contact the ECS Unit at EDS for a copy of the specifications.

Prior to billing electronically for payment, EDS will process provider supplied test claims to determine software formatting errors.

Refer to Appendix B for information and telephone contact numbers for ECS.

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Claim Submission, Continued

Electronic Funds Transfer

This process enables the ambulance services provider to receive Medicaid payments through automatic bank deposit. The RA report is mailed to the provider’s current mailing address.

Paper Claim Submission

Follow billing instructions included in this manual.

Processing Claims without Signature

Providers may file paper claims without an individual signature on each claim if the provider has submitted a Provider Certification for Signature on File form. (See Attachment C for a copy of the certification form.)

The certification must contain the provider’s original signature; stamped signatures are not accepted.

Time Limit

EDS must receive all Medicaid claims except hospital inpatient and nursing home claims within 365 days of the date of service in order to receive payment.

Time Limit Overrides

DMA and EDS have limited authority under federal regulations to override the billing time limit. The following are examples of acceptable documentation to review for time-limit override:

- ?? correspondence about the specific claim received from DMA or EDS
- ?? an explanation of Medicare benefits or other third party benefits dated within 180 days from the date payment or denial
- ?? a copy of the RA showing the claim pending or denied (the denial must be for reasons other than the time limit)

Claims with attachments for time-limit overrides must be sent to the Provider Services Unit at EDS. (Refer to Appendix B for address and telephone number.)

Submitting a billing date on claims only or a copy of the office ledger is not acceptable documentation. Submission dates do not verify that the claim was received within the 365-day time limit

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Claim Submission, Continued

Time-limit Overrides
(continued)

If the claim was received and processed originally within the 365-day limit, that claim can be refiled on paper or by ECS as a new day claim under the following guidelines:

- ?? claims must have exact match of recipient MID, provider number, from date of service, and total billed
- ?? claims which do not have an exact match on the EDS year-to-date history will be denied for one of the following EOBs:
 - EOB – 18: Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to the Provider Services Unit at EDS.
 - EOB – 8918 Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing – a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six (6) months.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Inquiry form and mail to the address indicated on the form. (See Attachment D for a copy of the Medicaid Resolution Inquiry form.)

Instructions for Completing the HCFA-1500 Claim Form

The following table contains instructions for completing the HCFA-1500 claim form (see Attachment E):

Form Locator/Description	Requirements	Remarks
1 Coverage Type	Required	Place an X in the Medicaid block.
1A Insured's ID Number	Required	Enter the patient's MID number (nine digits and the alpha suffix) from the patient's MID card.
2 Patient's Name	Required	Enter the patient's full name (last, first, middle initial) as it appears on the MID card.
3 Patient's Birthdate	Required	Enter six digits for the date of birth (MMDDYY). The birth date is on the Medicaid ID card. <i>EXAMPLE: November 14, 1949 is 111449.</i>
Patient's Sex		Place an X in the appropriate block to show the patient's sex.
4 Insured's Name	Desired	If the insured's name is the same as the name in block 2, enter same .
5 Patient's Address	Required	Enter complete address with street, city, and zip code. The telephone number is desired for Health Check claims, but is otherwise optional.

Continued on next page

Instructions for Completing the HCFA-1500 Claim Form, Continued

Form Locator/Description	Requirements	Remarks
6 – 8 Patient’s Relationship to Insured Insured’s Address Patient Status	Optional	
9 Other Insured’s Name	Required, where applicable	Enter private insurance information, if applicable.
9A Policy/Group Number	Required, where applicable	For Medicare/Medicaid claims, enter the MID number block 9A and 1A.
10 Patient Condition	Required	Place an X in the appropriate block.
11 – 14 Insured’s Policy/Group Number Patient’s Signature Insured’s Signature Date of Current Illness, Injury, or Pregnancy	Optional	
15 If Patient Has Had Same or Similar Illness Give First Date	Required	For OB/GYN claims, enter the date the patient was first seen for the pregnancy. For Health Check claims, enter the next screening date.
16 Date Patient Unable to Work in Current Occupation	Optional	
17 Referring Physician	Required, where applicable	Enter the name of the referring physician.
17A Referring Physician’s ID number	Required, where applicable	Enter the referring physician’s ID number.
18 Hospitalization Dates Related to Current Services	Optional	
19 Reserved for Local Use	Required for Carolina ACCESS recipients only	Enter the primary care physician’s provider number if service requires PCP approval.
20 Outside Lab?	Required, where applicable	Place an X in the appropriate block. “No” indicates that the lab work was performed in the office.
21 Diagnosis	Required	Enter the ICD-9-CM code describing the primary diagnosis related to the serviced. A related secondary diagnosis may also be entered. A written description is not required.
22 Medicaid Resubmission Code	Optional	

Continued on next page

Instructions for Completing the HCFA-1500 Claim Form, Continued

Form Locator/Description	Requirements	Remarks
23 Prior Authorization Number	Do Not Enter	Block 23 should remain blank.
24A Date(s) of Service	Required	Enter six digits (MMDDYY) for the date. "From" indicates the date that service began. "To" indicates the date that service ended.
24B Place of Service	Required	Enter the appropriate place of service.
24C Type of Service	Required	Enter the appropriate type of service.
24D Procedures, Services, or Supplies	Required	Enter the appropriate five-digit CPT code. No modifiers are accepted, except for Health Check claims.
24E Diagnosis Code	Optional	
24F Charges	Required	Enter the usual, customary charges for each procedure code billed.
24G Days or Units	Required, where applicable	Enter the number of visits – days or units.
24H EPSDT/Family Planning	Required, where applicable	If the service is a Health Check referral, enter E . If the service is related to family planning, enter F .
24I – 24K EMG COB Reserved for Local Use	Optional	
25 Federal Tax ID Numer	Optional	
26 Patient's Account Number	Optional	Enter the record or account number for the patient. The entry may be any combination of numbers and letters up to a total of nine characters. Entries will appear on the RA, which will assist in account reconciliation.
27 Accept Assignment	Optional	
28 Total Charge	Required	Enter the sum of the charges listed in block 24F.
29 Amount Paid	Required	Enter the total amount received from third party payment sources OTHER THAN MEDICARE . Do not enter Medicare payments or previous Medicaid payments.
30 Balance Due	Required	Subtract the amount in block 29 from the amount in block 28 and enter the result here.
31 Signature of Physician	Required	If a Certification of Signature on File form is not on file with EDS, an authorized representative must sign and date the claim in this block. A written signature stamp is acceptable.

Continued on next page

Instructions for Completing the HCFA-1500 Claim Form, Continued

Form Locator/Description	Requirements	Remarks
32 Name and Address of Facility	Optional	
33 Physician's Supplier's Billing Name, Address, and Phone Number PIN # Group #	Required	Enter the complete name, address, and telephone number. The name and address must appear EXACTLY as shown on the Medicaid participation agreement that applies to the service billed. Enter the individual physician's provider billing number. Enter the group number of the facility.

Medicaid Credit Balance Report

Medicaid Credit Balance Reporting

Providers are required to submit a quarterly Medicaid Credit Balance Report (see Attachment F) reporting all outstanding Medicaid credit balances reflected in the accounting records as of the last day of each calendar quarter.

The report is used to monitor and recover "credit balances" due to Medicaid. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. For example, if a provider is paid twice for the same services (e.g., by Medicaid and another insurer), a refund must be made to Medicaid.

What to Report

A Medicaid credit balance is an amount determined to be refundable to Medicaid. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in accounting records (patient accounts receivable) as a "credit." Medicaid credit balances, however, include money due the program regardless of its classification in a provider's accounting records.

For example, if a provider maintains a credit balance account for a stipulated period, e.g., 90 days, and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies due Medicaid.

When To Send the Report

Send the report to DMA no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31). **A report is required even if a zero (\$0.00) credit balance exists.**

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in the withholding of Medicaid payments until the report is received.

Continued on next page

Medicaid Credit Balance Report, Continued

Completing the Report Form The detail form requires specific information on each credit balance on a claim-by-claim basis. The detail form provides space for 15 claims, but it may be reproduced as many times as necessary to report all the required credit balances. Specific instructions for completing the report are on the reverse side of the report form.

Where To Send the Report Submit **only** the completed Medicaid Credit Balance Report to Third Party Recovery at the address listed in Appendix B.

Send any refunds due or recoupment requests to EDS with all the necessary documentation to process the refund or recoupment. **Do not** send refunds or recoupment requests to DMA.

The Medicaid Remittance and Status Report

Introduction The RA is a computer-generated document sent to providers showing the status of all claims submitted to EDS and a detailed breakdown of payments. (See Attachment G for a sample RA.)

How RAs Are Mailed The RA is produced at the same time checks are issued. If the RA is ten pages or less for any checkwrite, it will be mailed with the check. If more than ten pages, the RA will be mailed under separate cover.

Record Keeping Retain all RAs in chronological order to assist in keeping all claims and payment records current. If after checking the RA, a provider does not find information on questions about claims payment, contact the Provider Relations Unit at EDS for assistance.

1099 Form The last RA received each year serves as the annual 1099 Form.

Parts of the Remittance and Status Report

Introduction Information on the RA is identified by subject headings. Each major subject heading is further divided into subsections depending upon provider or claim type:

- ?? Paid Claims
- ?? Adjusted Claims
- ?? Denied Claims
- ?? Returned Claims
- ?? Claims in Process
- ?? Financial Items
- ?? Claims Summary
- ?? Claims Payment Summary
- ?? Totals by Population Grouping

Paid Claims This section shows all claims that have had payment activity since the previous checkwrite.

- ?? Each subsection is sequenced alphabetically by the recipient's last name.
- ?? Each subsection has summary totals.
- ?? A grand total summary of all paid claims subsections appears at the end of the paid claims section.

Adjusted Claims This section shows the status of claims when requests for action have been made to correct overpayments, underpayments, or payment to the wrong providers.

Some of the most common causes of adjustments are clerical errors, incorrect claims information, and incorrect procedure coding.

There are no subsections under this heading.

Denied Claims This section identifies those claims denied for payment.

- ?? Common reasons for claims denial are:
 - ?? eligibility status
 - ?? billing for noncovered services
 - ?? expired filing time limits
- ?? Claims in this section are divided into subsections to indicate the type of bill processed.
- ?? Recipient names are sequenced alphabetically in each subsection.
- ?? Zero will appear in all columns to the right of "Non-Allowed."
- ?? An explanation code specifying the reason for denial will appear in the far right column.

Denied claims are final, and no additional action will be taken on the claims unless the provider resubmits.

Continued on next page

Parts of the Remittance and Status Report, Continued

Returned Claims This section lists claims that cannot be processed by EDS for reasons such as missing medical records or omitted signatures. An unprocessed claim appears only once on the RA unless the provider resubmits it with the correct information. It will then appear as pending, paid, or denied.

Claims In Process This section lists those claims, which have been received and entered by EDS but are pending payment because further review of the claims is needed. Claims appearing in this section should not be rebilled.

Financial Items This section contains a listing of payments refunded by providers, amounts being recouped since the previous checkwrite, and other recoupment activities being applied which will reflect negatively on the provider's total earnings for the year. The explanation code beside each item indicates what action was taken.

Claims Summary The claims summary is divided into subsections and includes summary totals of revenue codes listed on the claims.

Claims Payment Summary This section summarizes all payments and credits made to the provider by the Medicaid program for the specific pay period, entitled "Current Processed," and for the year, entitled "Year To Date Total."

Totals by Population Grouping This section summarizes payments according to population group payer codes.

Explanation of Claim Number

Introduction

Each claim processed by EDS is assigned a unique 15-digit claim number followed by a 5-character financial payer code that appears on the RA. The claim number identifies how the claim was submitted, when EDS received the claim, and how it was processed. The fields on the claim number provide useful information to both providers and EDS on how claims are received and processed.

Fields of the Claim Number

Each claim number consists of five fields:

Region – indicates how the claim was submitted into the EDS.

Year – indicates the year the claim was.

Julian Date – indicates the date the claim was received in the EDS mailroom. The Julian calendar is used to identify the numeric day of the year (001 = January 1 and 365 = December 31).

Batch – each claim received is batched in groups of 100. Paper claims are microfilmed and given a unique 3-digit number for identification.

Batch Number – indicates the number of the claim within the batch of 100 (000 = first claim and 990 = last claim).

Explanation of Region

The table below explains how the region field (the first two number) of the claim number is assigned:

Region	Explanation
10	Paper Submission – A paper claim received in the EDS mailroom and keyed by EDS or contractor.
15	Electronic Submission (Tape) – An electronic claim submitted on magnetic tape.
25	Electronic Submission (PC) – An electronic claim submitted through a PC by modem or a mail-in diskette.
40	Medicare Crossover – Medicare crossover received by EDS from Medicare on magnetic tape. If the claim is automatically crossed over from Medicare and the provider submits the claim copy and EOMB, the claim number will begin with a 10, indicating a paper claim.
90 or 95	Adjustment Request – Adjustment requested by provider, EDS, or DMA. A previous payment was made on this claim.
96	System-generated adjustments for DRG replacement claims.

Continued on next page

Explanation of Claim Number, Continued

Examples

The table below explains several examples of claim numbers:

Region	Year	Julian Date	Batch	# Claim	Explanation
10	1998	001	300	000	Claim # 10 1998 001 300 000 indicates a paper claim received by the EDS mailroom on January 1, 1998. It is the first claim in batch 300.
15	1997	155	400	320	Claim # 15 1997 155 400 320 indicates a claim received by EDS via magnetic tape on June 4, 1997. It is the 32 nd claim in batch 400.
25	1997	182	400	010	Claim # 25 1997 182 400 010 indicates an electronic claim received by EDS on July 1, 1997. It is the first claim in batch 400.
40	1997	200	300	500	Claim # 40 1997 200 300 500 indicates a Medicare crossover claim received by EDS via magnetic tape on July 1, 1997. It is the 50 th claim in batch 300.
95	1997	352	500	990	Claim # 95 1997 352 500 990 indicates an adjusted claim received by EDS on December 18, 1997. It is the 99 th claim in batch 500.

Financial Payer Code

Each claim number is followed by a 5-character financial payer code that denotes the entity responsible for payment of the claims listed on the RA.

Claim Resubmission

Denied Claims

Claims not meeting required criteria will be denied. The EOB will inform the provider why the claim denied.

All information listed on the HCFA-1500 must be substantiated on the call report.

The following table describes the most common EOB codes and action needed to resolve claim denials:

EOB	MESSAGE	ACTION
011	Recipient not eligible on service date	Verify eligibility on recipient's MID card of through the Voice Inquiry System. If information is correct, check RA for keying errors. If no errors are found on the RA, claim, or MID card, submit copy of the claim and RA along with a copy of the MID card to the Claims Analysis Unit at DMA. (Refer to Appendix B for address.)
018	Has exceeded time limitation	Submit claim with RA showing the 18-month time limit and show first filing within 365 days from date of service.
021	Duplicate of claim-system	Reference RA date and claim number given under denied claims section. If this claim was not paid, call the Provider Services Unit at EDS. (Refer to Appendix B for telephone number.)
024	Revenue code is missing, invalid, or invalid for this bill type.	Verify the procedure/revenue code on the RA. If this information does not match the information on the claim, resubmit the claim. If this information matches, verify the code and type of service billed and submit corrected claim.

Continued on next page

Claim Resubmission, Continued

EOB	MESSAGE	ACTION
027	Diagnosis code is missing	<p>Verify and enter the correct diagnosis code and submit as a new claim.</p> <p>Possible reasons a claim may deny for this reason include:</p> <ul style="list-style-type: none"> ?? Invalid diagnosis code. ?? A zero is added to the end of the diagnosis code. (If the files do not indicate a zero at the end of the diagnosis, the zero will cause the diagnosis to be invalid in EDS system.) ?? When billing electronically, the provider include the decimal point. (The decimal is not included as part of the diagnosis code in the system.) <p>If claim is correct, contact the Provider Services Unit at EDS. (Refer to Appendix B for telephone number.)</p>
034	Indicate Part B Medicare payment in block 54	This EOB indicates Part B charges the need to be billed to Medicare Part B. After Medicare makes payment, indicate Medicare's Part B payment in block 54. In block 50, indicate Medicare Part B as the payer.
036	Revenue code invalid on this type of bill	Verify the revenue code for accuracy and check RA for keying errors. Resubmit corrected claim.
079	This service is not payable to your provider type in accordance with Medicaid guidelines.	The revenue code billed in not valid for the provider type billed. Contact the Provider Services Unit at EDS to verify codes and provider numbers billed. (Refer to Appendix B for telephone number.)
080	Units of service are not consistent with dates of service	Verify that the information in block 6 matched the information in block 7. Check the RA for keying errors.

Continued on next page

Claim Resubmission, Continued

EOB	MESSAGE	ACTION
094	Indicate insurance payment or attach denial and submit as a new claim	The third party insurance company code, recipient’s policy number, and policyholder’s name can be found on the RA. The insurance code can be found in the Third Party Insurance Code Book. Medicaid is always the payer of last resort, and all third party companies should be billed first. If that company denies the claim, submit a copy of the denial with the claim to EDS. If that company makes a payment, enter the amount of that payment in block 29 of the HCFA-1500. Medicaid will not make a payment unless the amount paid is less than the Medicaid-allowable.
143	Medicaid ID number not on state eligibility file	Verify that the number on the claim matches the number on the RA. If this information does not match, resubmit the claim. If this information matches, verify that the information is correct on the MID card. If all the information is correct, send a copy of the MID card, claim, and RA to the Claims Analysis Unit at DMA. (Refer to Appendix B for address.)
191	Medicaid ID number does not match patient name	Verify that the information on the MID card matches the information on the claim and the RA. If all of the information is correct, call the Provider Services Unit at EDS to verify the recipient’s name on the eligibility file. (Refer to Appendix B for telephone number.) EDS keys (for paper claims) the first two digits of the last name, the first digit of the first name and the MID number. If all three do not match, the result is a 191 denial.
8918	Insufficient documentation to warrant time-limit override	Resubmit claim with proof of timely filing – a previous RA, time-limit override letter, or other insurance payment or denial letter within the previous six months.

Adjustments

Instructions for Completing Medicaid Claim Adjustment Form

The Medicaid Claim Adjustment form (see Attachment H) is only used to adjust a previously paid claim or to make inquiry about denials not indicated on the list of EOBs.

Do not use the Adjustment form to inquire about a claim or to submit a claim for services that exceed filing time limit.

Attach the RA, the claim, and medical records related to the adjustment that justifies paying a previously denied claim/detail to the adjustment form.

The following table contains instructions for completing the Adjustment form:

Line	Instruction
Provider Number	Indicate the billing provider number.
Provider Name	Enter the name of billing provider.
Recipient Name	Enter the recipient's name as it appears on the MID card.
Recipient ID	Enter the recipient's ID number as it appears on the MID card.
Claim Number	Enter the Internal Claim Number (ICN) followed by the 5-character financial payer code as indicated on the RA. Always reference original ICN even if you have a subsequent denied adjustment.
Date of Service	Indicate the specific date of service covered on the original claim.
Billed Amount	Indicate amount billed on original claim.
Paid Amount	Enter amount paid on original claim.
RA Date	Enter the date the original claim was paid.
Type of Adjustment	Indicate reason for the adjustment (i.e., overpayment, underpayment, full recoupment, etc.).
Changes or Corrections to be Made	Indicate the reason for the adjustment (i.e., incorrect units processed and paid, incorrect date of service, third party liability, etc.).
Specific Reason for Adjustment Request	Indicate the reason for the adjustment. If the adjustment is a result of procedures not being combined, indicate the codes that are being combined. If the adjustment is necessitated by incorrect units, indicate the total number of correct units as it should have appeared on the original claim and the correct date of service.
Signature of Sender	Indicate the name of the person filling out the form.
Date	Indicate the date the adjustment request is submitted or mailed.
Phone number	Indicate the phone number for the person filling out the form.

Inquiries

Instructions for Completing Medicaid Resolution Inquiry Form

Use the Medicaid Resolution Inquiry form (see Attachment D) to submit claims for:
 ?? time limit overrides
 ?? TPL overrides
 ?? claims requiring overrides prior to processing such as Medicare Part A and B

Attach the RA, the claim, and other related information to the inquiry form.

The following table contains instructions for completing the Inquiry form:

Line	Instruction
Provider Number	Indicate the billing provider number.
Provider Name and Address	Enter the name and address of billing provider.
Recipient Name	Enter the recipient's name as it appears on the MID card.
Recipient ID	Enter the recipient's ID number as it appears on the MID card.
Date of Service	Indicate the specific date of service covered on the original claim.
Claim Number	Enter the Internal Claim Number (ICN) as indicated on the RA. Always reference original ICN even if you have a subsequent denied adjustment.
Billed Amount	Indicate amount billed on original claim.
Signature of sender and phone number	Indicate the name and phone number of the person filling out the form.

Provider Refunds

Introduction

When processing Medicaid claims, the following can occur: overpayments, third party reimbursements, and incorrect claim submissions. Two methods correct these occurrences: refunds or adjustments/recoupments. This section defines the requirements for issuing refunds to the Medicaid program and how these show on the RA.

Refunds Versus Adjustments

Both refunds and adjustments are acceptable means to reimburse the Medicaid program – the primary difference being where the cash outlay occurs. If adjustments are used, then payments on future RAs are reduced by the requested adjustment amount. Refunds do not affect future Medicaid payments in any way since the reimbursement is made directly from the provider's available funds.

Continued on next page

Provider Refunds, Continued

Refund Calculation

Refund the amount as based on the following criteria:

- ?? Duplicate Payment – Refund the full amount of the duplicate payment.
- ?? Overpayment Due To Incorrect Filing of Claim (e.g., billing amount error) – Refund the amount of the overpayment (i.e., incorrect Medicaid payment less correct Medicaid payment) or refund the full Medicaid payment and resubmit the claim for repayment.
- ?? Recipient Liability – Refund the amount Medicaid paid for which the recipient is responsible.
- ?? Overpayment Due to Medicare and Medicaid Both Paying as the Primary Insurer – Refund the amount of the Medicaid payment that exceeds the coinsurance and deductible of Medicare.
- ?? Other Health Insurance Payment – Refund the lesser of the two amounts received not to exceed the Medicaid payment amount. For example:

?? Amount billed by the provider to Medicaid	\$150.00
?? Amount paid by Medicaid	\$140.00
?? Amount paid by other health insurance	\$145.00
?? Amount to be reimbursed to Medicaid	\$140.00
?? Amount kept by provider	\$145.00

RA Documentation

Attach a copy of the RA to the refund check, highlighting the appropriate recipient and claim information along with the dollar amount of the refund to apply to that recipient. When refunding a particular line item of a recipient claim paid, highlight that specific line item for application of the refund. Without this RA documentation, EDS cannot apply a timely or correct refund. As a result, correct claims payment can be delayed or adjustments/recoupments may be processed.

No RA Documentation

If a copy of the RA cannot be supplied, the following information is required to properly apply the refund against the recipient claim history:

- ?? Provider number
- ?? Recipient name and MID number
- ?? Claim number (claim line item number if applicable)
- ?? Date of service
- ?? Dollar amount paid
- ?? Dollar amount of refund
- ?? Reason for refund (brief explanation)

This documentation can be supplied by any means available to the provider.

Continued on next page

Provider Refunds, Continued

Action Taken When Refunds Lack Adequate Documentation

When refunds are sent without adequate documentation as indicated above, EDS will send a letter to the provider requesting such documentation. If the documentation is not received within 30 days, EDS will apply these refunds to the determined provider number without detailed recipient claim history. If the refund was sent in error or was adjusted/recouped on a subsequent RA, then researching and resolving these refund inquiries without this documentation is further complicated and delayed. To ensure timely application and to avoid delay in correct claims payment, the required documentation needs to be supplied with each refund.

Where to Send the Refund

Refund checks must be made payable to EDS and mailed to EDS along with the required documentation as indicated above. (Refer to Appendix B for the address.)

Note: If DMA notifies the provider to refund monies, those funds are made payable to DMA and sent to DMA at the address indicated in the letter of request.

How Refunds Are Reflected on the RA

Once refunds are entered into the Medicaid system, the following data appears on the RA sent to the provider:

- ?? The Financial Items section of the RA contains a listing of the refunds applied and processed against the recipient claims history as indicated on the refund documentation.
 - ?? The EOB 113 is displayed for each refund transaction applied stating “refund amount applied to 1099 liability.”
 - ?? The Claims Payment Summary (last page of RA) indicates the total amount of refund applied in the “credit amount” field (i.e., to give the provider credit for returning those funds).
 - ?? As a result of returning those funds, the “net 1099 amount” field is decreased by the “credit amount” to ensure the IRS is informed of the correct amount of monies earned and kept by the provider.
 - ?? Refund transactions do not affect the “claims paid,” “claims amount,” “withheld amount,” or “net pay” amount fields of this section (i.e., refunds do not affect the amount paid to the provider but only the amount reported to the IRS).
-

Tax Identification Information

Tax Information Maintenance

The North Carolina Medicaid program must have proper tax information for all providers. This ensures correct issuance of 1099 MISC forms each year and that the correct tax information is provided to the IRS.

Continued on next page

Tax Identification Information, Continued

Tax Information Verification The provider tax name and number (FEIN) that Medicaid has on file is on the last page of the RA. Review the RA periodically to ensure that the information for each provider number is correct. Tax information on file may also be verified by contacting the Provider Services Unit at EDS. (Refer to Appendix B for telephone number.)

Group Practice Tax Information Tax information needed for a group practice:

- ?? group tax name
- ?? group tax number
- ?? attending Medicaid providers in group

Correcting The Tax Number Opticians must report all changes in provider status to DMA using the Notification of Changes in Provider Status form (see Attachment B).

Optometrists and ophthalmologists must report changes in their provider status to their regional BCBS Representative.

If you are also participating in the Medicaid program as a Managed Care provider, changes must be reported to your local Managed Care Representative (MCR). Refer to Appendix B for telephone numbers.

Change Of Ownership Providers are required to report changes of ownership with 30 days of the change.

Opticians must report all changes in provider status to DMA using the Notification of Changes in Provider Status form (see Attachment B).

Optometrists and ophthalmologists must report changes in their provider status to their regional BCBS Representative.

If you are also participating in the Medicaid program as a Managed Care provider, changes must be reported to your local Managed Care Representative (MCR). Managed Care providers must **also** report changes to their local Managed Care Representative.

Optometrists must report changes to their regional Blue Cross Blue Shield Representative,

DMA Provider Services will assist in enrollment for a Medicaid provider number and ensure that the correct tax information is on file. If DMA is not contacted and a provider number with incorrect tax data continues to be used, the provider using that number could become liable for taxes on income not received them. Refer to Appendix B for telephone number.

Attachments

Attachment A is the Health Insurance Information Referral Form (DMA-2057)

Attachment B is the Recovery Accident Information form (DMA-2043)

Attachment C is the Provider Certification for Signature on File form

Attachment D is the Medicaid Resolution Inquiry form

Attachment E is the of the HCFA -1500 claim form

Attachment F is the Medicaid Credit Balance Report form

Attachment G is a sample of the Remittance and Advice Report

Attachment H is the Medicaid Claim Adjustment form

Division of Medical Assistance

Health Insurance Information Referral Form

Recipient Name: _____

Recipient ID No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy/Cert No. _____

(2) _____ Policy/Cert No. _____

Reason For Referral

1. _____ Patient not covered by above policy(s)
2. _____ Service not covered by above policy(s)
3. _____ Insurance company denied by _____ letter or _____ telephone
(please provide name and number of contact person and reason for denial):

4. New policy not indicated on Medicaid ID card. Indicate type coverage:

_____ Major Medical	_____ Hosp/Surgical	_____ Basic Hospital
_____ Dental	_____ Cancer	_____ Accident
_____ Indemnity	_____ Nursing Home	

5. Insurance company paid patient \$ _____ Date _____ and patient has not paid provider.

If items 1 through 3 are checked, attach original claim and submit to: The Division of Medical Assistance, Third Party Recovery Section, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will verify the information and will either override or reject the claims within 10 working days after receipt.

Item 4 should be used if the patient requests filing with an insurance company that is not indicated on the Medicaid ID card. The TPR Section will enter this information into the TPR database.

Submitted: _____ Provider Number: _____

By: _____ Date Submitted: _____

Telephone Number: _____

Telephone Number (919) 733-6294

DMA 2043

(Rev. 1-01)

**NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE**

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

Print or Type Business Name of Provider

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

Return completed form to: EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622

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PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0508-0008

HEALTH INSURANCE CLAIM FORM

CARRIER

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) **123-45-6789-2**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Seymor, Iwana** 3. PATIENT'S BIRTH DATE MM DD YY **05 22 74** SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) **1234 Twenty-Twenty** 6. PATIENT RELATIONSHIP TO INSURED Sell Spouse Child Other 7. INSURED'S ADDRESS (No. Street)

CITY **Sea Level** STATE **NC** 8. PATIENT STATUS Single Married Other CITY STATE

ZIP CODE **12345** TELEPHONE (Include Area Code) **(999) 555-2020** Employed Full-Time Student Part-Time Student ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. AUTO ACCIDENT? YES NO PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 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. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24	A	B	C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE From MM DD YY To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1	01 01 01	11	10	92004		50.00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN/EIN 26. PATIENT'S ACCOUNT NO. **1111-01** 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE \$ **50.00** 29. AMOUNT PAID \$ 30. BALANCE DUE \$ **50.00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) 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 # **Dr. I Glasses P.O. Box 123 Visual, NC 12345** PIN# **8900000** GRP#

SIGNED DATE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE (8/88) PLEASE PRINT OR TYPE FORM HCFA 1500 (12-90) FORM DWCP-1500 FORM RRB-1500

PHYSICIAN OR SUPPLIER INFORMATION

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

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG AND FECA CLAIMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) **123-45-6789-Z**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Seymor, Iwana**

3. PATIENT'S BIRTH DATE MM DD YY **05 22 74** SEX M F

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

5. PATIENT'S ADDRESS (No., Street) **1234 Twenty-Twenty**

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY **Sea Level** STATE **NC**

8. PATIENT STATUS Single Married Other

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

10. IS PATIENT'S CONDITION RELATED TO: Employed Full-Time Student Part-Time Student

11. INSURED'S POLICY GROUP OR FECA NUMBER

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.

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

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES

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

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	A		B	C	D	E	F	G	H	I	J	K
	From	To										
1	04	01	01	11	15	V0500		15.00	2			
2												
3												
4												
5												
6												

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 \$ **15.00**

29. AMOUNT PAID \$

30. BALANCE DUE \$ **15.00**

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.)

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 # **Dr. I. Glasses
P.O. Box 123
Visual, NC 12345**

SIGNED _____ DATE _____

PIN# **8900000** GRP# _____

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

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

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

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

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

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

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

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

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

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

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

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: (_____) _____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) Medicaid NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) Medicaid ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
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1.

2.

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5.

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10.

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14.

15.

Circle one: Refund Adjustment

Revised 8/00

(See back of form for instructions)

**Return form to: Third Party Recovery
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508**

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- ?? Full name of facility as it appears on the Medicaid Records
- ?? The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number, DO NOT MIX
- ?? Circle the date of quarter end
- ?? Enter year
- ?? The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

- Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)
- Column 2 - The individual Medicaid identification (MID) number
- Column 3 - The month, day, and year of beginning service (e.g., 12/05/99)
- Column 4 - The month, day, and year of ending service (e.g., 12/10/99)
- Column 5 - The R/A date of Medicaid payment (not your posting date)
- Column 6 - The Medicaid ICN (claim) number
- Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)
- Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

**NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT**

XYZ CORPORATION
PO BOX 1111
ANYWHERE, NC 22222

PROVIDER NUMBER 8900000				REPORT SEQ. NUMBER 21				DATE 09/28/2000		PAGE 2					
NAME	SERVICE DATES		DAYS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANA- TION CODES			
RECIPIENT ID	FROM	TO	OR												
POPULATION GROUP	MM DD CCYY	MM DD CCYY	UNITS												
PAID CLAIMS MEDICAL															
EDWARDS MARY 912345555A	D CO=41 RCC=			CLAIM NUMBER=252000165181580/NCXIX											
NCXIX	04012000	04302000	30 A 100	ALL-INCLUSIVE R&B PLUS ANCI	243540	00	243540	00	243540	72300	171240	8925 8925			
	DEDUCTIBLE=	.00	PAT LIAB=	723.00	CO PAY=	.00	TPL=	.00	243540	00	243540	00	243540	72300	171240
****->	TOTAL PAID CLAIMS			1	CLAIMS		243540	00	243540	00	243540	72300	171240		

Date received back in the Adjustment Department: _____/_____/_____

Revised: 08/21/00

