

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:
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Enrollee Identification Number:
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Enrollee Last Name:	First Name:	MI:
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<input type="checkbox"/> Paper Attached	<input type="checkbox"/> Photo(s) Attached	<input type="checkbox"/> X-Ray(s) Attached
<input type="checkbox"/> Other (specify) _____		

COMMENTS: _____ _____ _____ _____ _____
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THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.) IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.
2. **Date of Service** – Enter the from date of service the attachment applies to.
3. **Sequence Number** – Enter the provider generated sequence number up to 5 digits only.
4. **Provider Number** – Enter the Medicaid Provider number.
5. **Provider Name** – Enter the name of the Provider.
6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.
7. **Enrollee Last Name** - Enter the last name of the Enrollee.
8. **First** – Enter the first name of the Enrollee.
9. **MI** – Enter the middle initial of the Enrollee.
10. **Type of Attachment** – Check the type of attachment or specify.
11. **Comment** – Enter comments if necessary.
12. **Authorized Signature** – Signature of the Provider or authorized Agent.
13. **Date Signed** – Enter the date the form was signed.

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