

CHAPTER V
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CHAPTER V BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines.

Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing. For more information contact our fiscal agent, Xerox State Healthcare, LLC:

Phone: (866)-352-0766
Fax number: (888)-335-8460
Website: <https://www.virginiamedicaid.dmas.virginia.gov> or by mail

Xerox State Healthcare, LLC
EDI Coordinator
Virginia Medicaid Fiscal Agent
P.O. Box 26228
Richmond, Virginia 23260-6228

DIRECT DATA ENTRY (DDE)

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare

Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.viriniamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service**. If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

BILLING INVOICES

The requirements for submission of billing information and the use of the appropriate billing invoice depend upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used for billing vision care services:

- Health Insurance Claim Form CMS-1500 (02-12)

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processors will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather the Virginia Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Medicaid provider number and use qualifier “ID” in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Medicare will reduce the need for submitting follow-up paper claims.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202) 512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by:

Mail Your Request To:
Commonwealth Mailing
1700 Venable St.,
Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pending, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in

sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, Xerox State Healthcare, LLC at (866) 352-0766.

CLAIM INQUIRIES AND RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273 Richmond Area and out-of-state long distance
1-800-552-8627 In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996 Toll-free throughout the United States
1-800- 884-9730 Toll-free throughout the United States
1-804- 965-9732 Richmond and Surrounding Counties
1-804- 965-9733 Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

Or

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010)

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides> or contact EDI Support at [1-866-352-0766](tel:1-866-352-0766) or Virginia.EDISupport@xerox.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website:

<https://www.viriniamedicaid.dmas.virginia.gov>.

CLAIMCHECK

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.
- PTP Edits:
CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note:** Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.
- MUE Edits:
DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE,

potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- **Exempt Provider Types**
DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC), Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.
- **Service Authorizations:**
DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.
- **Modifiers:**
Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1" or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a

reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

VACCINE BILLING INFORMATION

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under the Vaccines For Children (VFC) program. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Centers for Medicare and Medicaid Services (CMS) requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the "Service Authorization" Appendix in the manual.

BASIS OF PAYMENT

A request for payment must be made under the Medicaid eligibility number of the person receiving the services and whose Medicaid eligibility number appears on the billing invoice.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service rendered. The provider may not bill DMAS or the member for the difference (if any) between the allowed charge and the provider's actual charge.

The provider must bill any other possibly liable third party prior to billing DMAS. Provider must submit bill within 12 months from date of service. DMAS will pay the difference between the Program's allowable fee and any payment made by another third party if that payment is less than the allowable fee.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the services if it were billed solely to Medicaid.

BILLING FOR MEMBERS IN THE CLIENT MEDICAL MANAGEMENT PROGRAM TREATED ON REFERRAL FROM THE PRIMARY CARE PHYSICIAN

Annual or routine vision examinations (under age 21) do not require referral from the primary care physician. For all non-routine vision care services, the provider who treats a member on referral from the **primary care provider** must place the **primary care** provider number (as indicated on the ID card) in Locator 17a of the claim form. A copy of the Practitioner Referral Form (DMAS-70) must be attached to the invoice. As the billing instructions indicate.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. In this case, the provider must mark Locator 24I of the CMS-1500 (12-90) or locator 24C of CMS-1500 (08/05) claim form (used to indicate that the situation was an emergency, that is, truly life-threatening), enter "ATTACHMENT" in Locator 10d, and explain the nature of the circumstances on an attachment to the CMS-1500 claim form.

STARTING 04/01/2014 AND AFTER

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims **received on or after April 1, 2014**. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

<u>Locator</u>		<u>Instructions</u>
1	REQUIRED	Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).
1a	REQUIRED	Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT	Reserved for NUCC Use

Locator		Instructions
9	REQUIRED NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	Conditional	Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim form.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	REQUIRED If applicable	Insurance Plan or Program Name Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay".
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	REQUIRED If Applicable	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	REQUIRED If applicable	Name of Referring Physician or Other Source – Enter the name of the referring physician.

<u>Locator</u>		<u>Instructions</u>
17a shaded red	REQUIRED If applicable	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	REQUIRED If applicable	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	REQUIRED If applicable	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 A-L	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. Note: ICD Ind. OPTIONAL 9= ICD-9-CM – Dates of service through 09/30/2015 0=ICD-10-CM – Dates of service 10/01/15 and after
22	REQUIRED If applicable	Resubmission Code – Original Reference Number. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	REQUIRED If applicable	Prior Authorization (PA) Number – Enter the PA number for approved services that require a service authorization.
<p>NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.</p>		
24A lines 1-6 open area	REQUIRED	Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

<u>Locator</u>	<u>Instructions</u>
----------------	---------------------

24A
lines
1-6
red
shade
d

REQUIRED
If applicable

DMAS requires the use of qualifier 'TPL'. This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is \$27.08; red shaded area would be filled as **TPL27.08**. No spaces between qualifier and dollars. No \$ symbol but the decimal between dollars and cents is required.

DMAS requires the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.

NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity

Unit of Measurement Qualifier Codes:

F2 – International Units

GR – Gram

ML – Milliliter

UN – Unit

Examples of NDC quantities for various dosage forms as follows:

a. Tablets/Capsules – bill per UN

b. Oral Liquids – bill per ML

c. Reconstituted (or liquids) injections – bill per ML

d. Non-reconstituted injections (I.E. vial of Rocephin

powder) – bill as UN (1 vial = 1 unit)

e. Creams, ointments, topical powders – bill per GR

f. Inhalers – bill per GR

BILLING EXAMPLES:

TPL, NDC and UOM submitted:

TPL3.50N412345678901ML1.0

NDC, UOM and TPL submitted:

Locator	Instructions
	N412345678901ML1.0TPL3.50

NDC and UOM submitted only:

N412345678901ML1.0

TPL submitted only:

TPL3.50

Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)
All supplemental information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:

- If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.
- If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. **An EOB/documentation must be attached to the claim to verify non payment.**
- If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of \$15.50. This relates to the old coordination of benefit code 3.

24B open area	REQUIRED	Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.
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24C open area	REQUIRED If applicable	Emergency Indicator - Enter either 'Y' for YES or leave blank. DMAS will not accept any other indicators for this locator.
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24D open area	REQUIRED	Procedures, Services or Supplies – CPT/HCPCS – les Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.
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24E	REQUIRED	Diagnosis Code - Enter the diagnosis code reference
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<u>Locator</u>		<u>Instructions</u>
open area		letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank may be denied.
24F open area	REQUIRED	Charges - Enter your total usual and customary charges for the procedure/services.
24G open area	REQUIRED	Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	REQUIRED If applicable	EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	REQUIRED If applicable	NPI – This is to identify that it is a NPI that is in locator 24J
24 I red-shaded	REQUIRED If applicable	ID QUALIFIER –The qualifier ‘ZZ’ can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier ‘1D’ is required for the API entered in locator 24J red shaded line.
24J open	REQUIRED If applicable	Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red-shaded	REQUIRED If applicable	Rendering provider ID# - The qualifier ‘1D’ is required for the API entered in this locator. The qualifier ‘ZZ’ can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	REQUIRED	Patient's Account Number – Up to FOURTEEN alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment

<u>Locator</u>	<u>Instructions</u>	
28	REQUIRED	Total Charge - Enter the total charges for the services in 24F lines 1-6
29	REQUIRED If applicable	Amount Paid – For personal care and waiver services only – enter the patient pay amount that is due from the patient. NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	REQUIRED	Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.
32	REQUIRED If applicable	Service Facility Location Information – Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	REQUIRED If applicable	NPI # - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED If applicable	Other ID#: - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	REQUIRED	Billing Provider Info and PH # - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	REQUIRED	NPI – Enter the 10 digit NPI number of the billing provider.

**33b
red
shaded**

**REQUIRED
If applicable**

Other Billing ID - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line.

NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (02-12), as an Adjustment Invoice

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/service code
1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (08-05) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier

600 East Broad St. Suite 1300
Richmond, VA 23219

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (08-05) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, "less the negative balance" and it may also show "the negative balance to be carried forward".

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of \$1000.00 and the provider has a negative balance of \$2000.00 a check will not be issued, and the remaining \$1000.00 outstanding to DMAS will carry forward to the next remittance.

Telemedicine Billing Information

The following DMAS covered Current Procedural Terminology (CPT) codes are recognized by DMAS for telemedicine. The services are rendered by providers at the "hub" site to the Medicaid member located at the distant or "spoke" site:

- CPT 99241-99255, consultations;
- CPT 99201-99215, office visits;
- CPT 90804-90809, individual psychotherapy;
- **CPT 90801, psychiatric diagnostic interview examination**
- CPT 90862, pharmacologic management;
- CPT 57452, 57454, 57460, colostomy;
- CPT 76805, 76810, obstetric ultrasound;
- CPT 76825, echocardiography, fetal;
- CPT 93010, cardiography interpretation and report only; and
- CPT 93307, 93308, 93320, 93321, 93325, echocardiography.

The CMS 1500 is to be used to bill for covered telemedicine services, with the appropriate billing code entered in block 24D and "GT" entered as the modifier. The distant or "spoke" site provider is where the DMAS member is located for the

telemedicine encounter. The member must be present for the encounter as well as the provider. HCPCS code Q3014 is to be billed for the spoke site service unless the hub provider determines a higher-level service must be documented in the member's medical record. Again, "GT" is to be entered as the modifier when billing. For DMAS covered physician services, a Registered Nurse under the supervision of a physician may attend the telemedicine encounter and assist the member. This service is billed using code Q3014. After reviewing the documentation for the encounter, the physician must sign and date the documentation and billing.

SPECIAL BILLING INSTRUCTIONS CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D' and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "Y" in Locator 24C and attach an explanation of the nature of the emergency.

<u>LOCATOR</u>	<u>SPECIAL INSTRUCTIONS</u>
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.
17	Enter the name of the referring primary care provider.
17a red shaded	When a restricted enrollee is treated on referral from the primary physician, enter the qualifier '1D' and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d. Note: Please refer to the time line for the appropriate provider number as indicated in main instruction above.
17b open	When a restricted enrollee is treated on referral from the primary physician, enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to

the invoice. Write "ATTACHMENT" in Locator 10d.

Note: This locator can only be used for claims received on or after Late- February 2007.

- 24C** When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "Y" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

SPECIAL BILLING INSTRUCTIONS – HEALTH DEPARTMENTS (DRUGS, FAMILY PLANNING AND NUTRITIONAL SUPPLEMENTS)

Tuberculosis Oral Drugs

Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499. Modifier U2 must be used in Block 24-D of the CMS-1500 (08-05) claim form. Clinics bill Medicaid with their actual cost for the drugs. If no modifier is billed, the claim may be denied. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family Planning Drugs and Devices

Birth control pills must be billed using code J8499 along with modifiers FP and U2 in Block 24-D of the CMS-1500 (08-05) claim form. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family planning supplies (such as condoms, Intrauterine Devices, etc) should be billed using unlisted supply code 99070 with the FP and U2 modifiers. Actual costs for the drugs and supplies should be reflected in the charges. Claims submitted without the modifiers may be denied.

Nutritional Supplements

Nutritional Supplements should be billed using the national HCPCS codes for Enteral and Parenteral Therapy (B4000-B9999) with the U2 modifier in Block 24-D of the CMS-1500 (08-05) claim form. Actual cost for the supplements should be billed. If no modifier is billed, the claim may be denied.

PLACE OF SERVICE CODES

CMS - 1500 CODE

00-10	Unassigned
11	Office location
12	Patient's home
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center
25	Birth center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
35-40	Unassigned
41	Ambulance - land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

PROCEDURE MODIFIERS

HCPCS/CPT

TC	Technical Component
22	Unusual services
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
75	Concurrent care
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon

SPECIAL BILLING INSTRUCTIONS

VISION MANUAL

Locator 21 Diagnosis or Nature of Illness or Injury - Enter the diagnosis code Z01.00, Z01.01 for routine eye exams and for eyeglasses; otherwise, enter the appropriate ICD-CM diagnostic code.

Locator 24D Procedures, Services, or Supplies - Enter the applicable code. See Appendix B for the codes for routine eye exams and for eyeglasses; otherwise, use the appropriate HCPCS code.

Locator 24G Days or Units - For eyeglasses, one lens is considered one unit; two lenses, two units. Eyeglass frames are considered one unit.

When a Medicare vision care provider bills Medicare for a medical procedure and an eye refraction is part of the service, the refraction is not covered by Medicare. Medicare denies it as a non-covered service. To bill Medicaid for the refraction, use CPT procedure code 92015 (determination of refractive state) on the CMS-1500 form.

INSTRUCTIONS FOR BILLING MEDICARE CROSSOVER PART B SERVICES

The Virginia Medical Assistance Program implemented the consolidation process for Virginia Medicare crossover process, referred to as the Coordination of Benefits Agreement (COBA) in January 23, 2006. This process resulted in the transferring the claims crossover functions from individual Medicare contractors to one national claims crossover contractor.

The COBA process is only using the 837 electronic claims format. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides>) for more information.

Beginning March 1, 2006, Virginia Medicaid began accepting secondary claims to Medicaid when Medicare is primary from providers and not just thru the COBA process. If you receive notification that your Medicare claims did not cross to Virginia Medicaid or the crossover claim has not shown on your Medicaid remittance advice after 30 days, you should submit your claim directly to Medicaid. These claims can be resubmitted directly to DMAS either electronically, via Direct Data Entry or by using the CMS 1500 (02-12) paper claim form. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides>) for more information.

An electronic claim can be sent to Virginia Medicaid if you need to resubmit a crossover claim that originally denied, such as for other coverage, or if you need to adjust or void a paid crossover claim, such as to include patient liability.

NOTE: Medicaid eligibility is reaffirmed each month for most members. Therefore, bills must be for services provided during each calendar month, e.g., 01/01/06 – 01/31/06.

**DEDUCTIBLE, COINSURANCE AND COPAY PAYMENTS FOR
PROFESSIONAL SERVICES (Effective 11/2/2014)**

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Webportal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose: A method of billing Medicare's deductible, coinsurance and copay for professional services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS-1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12)

NOTE: Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

<u>Locator</u>		<u>Instructions</u>
1	REQUIRED	Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).
1a	REQUIRED	Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT	Patient's Address

<u>Locator</u>	<u>Instructions</u>
6	REQUIRED NOT REQUIRED Patient Relationship to Insured
7	NOT REQUIRED Insured's Address
8	NOT REQUIRED Reserved for NUCC Use
9	NOT REQUIRED Other Insured's Name
9a	NOT REQUIRED Other Insured's Policy or Group Number
9b	NOT REQUIRED Reserved for NUCC Use
9c	NOT REQUIRED Reserved for NUCC Use
9d	NOT REQUIRED Insurance Plan Name or Program Name
10	REQUIRED Is Patient's Condition Related To: - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
10d	Conditional Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim form. Medicare/Medicare Advantage Plan EOB should be attached.
11	NOT REQUIRED Insured's Policy Number or FECA Number
11a	NOT REQUIRED Insured's Date of Birth
11b	NOT REQUIRED Other Claim ID
11c	REQUIRED Insurance Plan or Program Name Enter the word 'CROSSOVER' IMPORTANT: DO NOT enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word 'CROSSOVER'
11d	REQUIRED If applicable Is There Another Health Benefit Plan? If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage other than Medicare/Medicare Advantage Plan and Medicaid.
12	NOT Patient's or Authorized Person's Signature

Locator		Instructions
13	REQUIRED NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shade d red	NOT REQUIRED	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab?
21 A-L	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. Note: ICD Ind. OPTIONAL 9= ICD-9-CM – Dates of service through 9/30/15 0=ICD-10-CM – Dates of service 10/1/15 and after
22	REQUIRED If applicable	Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment: 1023 Primary Carrier has made additional payment 1024 Primary Carrier has denied payment

Locator

Instructions

- 1026 Patient payment amount changed
- 1027 Correcting service periods
- 1028 Correcting procedure/service code
- 1029 Correcting diagnosis code
- 1030 Correcting charges
- 1031 Correcting units/visits/studies/procedures
- 1032 IC reconsideration of allowance, documented
- 1033 Correcting admitting, referring, prescribing provider identification number
- 1053 Adjustment reason is in the miscellaneous category

Enter one of the following resubmission codes for a **void**:

- 1042 Original claim has multiple incorrect items
- 1044 Wrong provider identification number
- 1045 Wrong member eligibility number
- 1046 Primary carrier has paid DMAS' maximum allowance
- 1047 Duplicate payment was made
- 1048 Primary carrier has paid full charge
- 1051 Member is not my patient
- 1052 Void reason is in the miscellaneous category
- 1060 Other insurance is available

Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead

<u>Locator</u>	<u>Instructions</u>
	which includes the current address, contact name and phone number. <ul style="list-style-type: none"> • An explanation about the refund. • A copy of the remittance page(s) as it relates to the refund check amount. • Mail all information to: Department of Medical Assistance Services Attn: Fiscal & Procurement Division, Cashier 600 East Broad St. Suite 1300 Richmond, VA 23219
23	<p>REQUIRED If applicable Prior Authorization (PA) Number – Enter the PA number for approved services that require a service authorization.</p> <p>NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. <u>ENTER REQUIRED INFORMATION ONLY.</u></p>
24A lines 1-6 open area	<p>REQUIRED Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).</p>
24A-H lines 1-6 red shaded	<p>REQUIRED If applicable NEW INFORMATION! DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:</p> <p>A1 = Deductible (Example: A120.00) = \$20.00 ded A2 = Coinsurance (Example: A240.00) = \$40.00 coins A7= Copay (Example: A735.00) = \$35.00 copay AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = \$145.10 Allowed Amount MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable</p>

Locator

Instructions

(Example CM27.08) see details below

N4 = National Drug Code (NDC)+Unit of Measurement

'MA': This qualifier is to be used to show **Medicare/Medicare Advantage Plan's** payment. The **'MA'** qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan

Example:

Payment by Medicare/Medicare Advantage Plan is \$27.08; enter **MA27.08** in the red shaded area

'CM': This qualifier is to be used to show the amount paid by the insurance carrier **other than Medicare/Medicare Advantage plan**. The **'CM'** qualifier is to be followed by the dollar/cents amount of the payment by the other insurance.

Example:

Payment by the other insurance plan is \$27.08; enter **CM27.08** in the red shaded area

NOTE: No spaces are allowed between the qualifier and dollars. No \$ symbol is allowed. The decimal between dollars and cents is required.

DMAS is requiring the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC.

Example: N400026064871UN1.0

Any spaces unused for the quantity should be left blank.

Unit of Measurement Qualifier Codes:

F2 – International Units

GR – Gram

ML – Milliliter

UN – Unit

Examples of NDC quantities for various dosage forms as follows:

a. Tablets/Capsules – bill per UN

b. Oral Liquids – bill per ML

c. Reconstituted (or liquids) injections – bill per ML

<u>Locator</u>	<u>Instructions</u>
	d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit) e. Creams, ointments, topical powders – bill per GR f. Inhalers – bill per GR

Note: All supplemental information entered in locator 24A thru 24H is to be left justified.

Examples:

1. Deductible is \$10.00, Medicare/Medicare Advantage Plan Allowed Amt is \$20.00, Medicare/Medicare Advantage Plan Paid Amt is \$16.00, Coinsurance is \$4.00.
 - Enter: A110.00 AB20.00 MA16.00 A24.00
2. Copay is \$35.00, Medicare/Medicare Advantage Plan Paid Amt is \$0.00 Medicare/Medicare Advantage Plan Allowed Amt is \$100.00
 - Enter: A735.00 MA0.00 AB100.00
3. Medicare/Medicare Advantage Plan Paid Amt is \$10.00, Other Insurance payment is \$10.00, Medicare/Medicare Advantage Plan Allowed Amt is \$10.00, Coinsurance is \$5.00, NDC is 12345678911, Unit of measure is 2 grams
 - Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2

****Allow a space in between each qualifier set****

24B open area	REQUIRED	Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	REQUIRED If applicable	Emergency Indicator - Enter either 'Y' for YES or leave blank. DMAS will not accept any other indicators for this locator.

<u>Locator</u>		<u>Instructions</u>
24D open area	REQUIRED	Procedures, Services or Supplies – CPT/HCPCS – les Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	REQUIRED	Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank will be denied.
24F open area	REQUIRED	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.
24G open area	REQUIRED	Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	REQUIRED If applicable	EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	REQUIRED If applicable	NPI – This is to identify that it is a NPI that is in locator 24J
24 I red- shade d	REQUIRED If applicable	ID QUALIFIER –The qualifier ‘ZZ’ can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier ‘1D’ is required for the API entered in locator 24J red shaded line.

<u>Locator</u>	<u>Instructions</u>	
24J open	REQUIRED If applicable	Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red- shaded	REQUIRED If applicable	Rendering provider ID# - If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	REQUIRED	Patient's Account Number – Up to FOURTEEN alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	REQUIRED	Total Charge - Enter the total charges for the services in 24F lines 1-6
29	REQUIRED If applicable	Amount Paid – For personal care and waiver services only – enter the patient pay amount that is due from the patient. NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	REQUIRED	Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.
32	REQUIRED If applicable	Service Facility Location Information – Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	REQUIRED If applicable	NPI # - Enter the 10 digit NPI number of the service location.

<u>Locator</u>		<u>Instructions</u>
32b red shaded	REQUIRED If applicable	Other ID#: - The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 32a open line.
33	REQUIRED	Billing Provider Info and PH # - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	REQUIRED	NPI – Enter the 10 digit NPI number of the billing provider.
33b red shaded	REQUIRED If applicable	Other Billing ID - The qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line. NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files.

Mail the completed claims to:

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, microfilmed, assigned a cross-reference number (e.g. 123-45678-9) and entered into the system, it is placed in one of the following categories as indicated on your remittance voucher.

- **Approval** - Payment is approved.

- **Pend** - For manual review & adjudication (The provider must not resubmit.)
- **Denied** - Payment cannot be approved for the reason stated on the remittance voucher.
- **No Response** - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual*.

EXHIBITS

EXHIBITS TABLE OF CONTENTS

Health Insurance Claim Form CMS-1500 (02-12)	1
Request for Billing Supplies DMAS 160	2
Request for Forms/Brochures DMAS 161	3

Note: Do Not make copies of claim form from the exhibits to submit.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE (NUCC) 6/9/12

IPICA

IPICA

1. MEDICARE (Medicare #) <input type="checkbox"/>	MEDICAID (Medicaid #) <input type="checkbox"/>	TRICARE (ID#/DoD#) <input type="checkbox"/>	CHAMPVA (Member ID#) <input type="checkbox"/>	GROUP HEALTH PLAN (ID#) <input type="checkbox"/>	FECA BLK LUNG (ID#) <input type="checkbox"/>	OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Programs in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d.</i>						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____							13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LIZP) MM DD YY QUAL			16. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. RESUBMISSION CODE ORIGINAL REF. NO.						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Refer to A-L to service fee below (24E)			ICD Ind. _____		23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS ICD9-CM	F. \$ CHARGES	G. DAYS OR HOURS	H. I.D. #	I. QUAL	J. RENDERING PROVIDER ID, #
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If only the statements on this reverse apply to this bill and are made a part thereof)			32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PHL # ()						
SIGNED _____ DATE _____			a. _____ b. _____		a. _____ b. _____						

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1600CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR BILLING SUPPLIES

Name _____ Date _____

Provider Number _____ Contact Person _____

Telephone # (_____) _____

Area Code _____

Check as appropriate:

_____ Please forward preprinted invoices as indicated below.

_____ Please forward invoices suitable for computer use as indicated below.

_____ Other (See order below.)

Quantity Dental Quantity Pharmacy

_____ DMAS-701 Invoice _____ DMAS-173 Drug Claim Ledger

_____ DMAS-702 Invoice Adjustment _____ DMAS-228 Drug Claim Adjustment

_____ DMAS-704 Preauthorization Request _____ DMAS-664 Envelope

_____ DMAS-703 Envelope

Home Health Agency Practitioner

_____ DMAS-662 Envelope _____ DMAS-663 Envelope

Hospital Title XVIII NOT PREPRINTED

_____ DMAS-660 Envelope _____ DMAS-30 (Medicare) Deductible

and Coinsurance Invoice

SLH _____ DMAS-31 Invoice Adjustment

_____ SLH-24 Mailing Envelope

Personal Care NOT PREPRINTED Transportation NOT PREPRINTED

_____ DMAS-89 Personal Care Recipient

Admissions Envelope

_____ DMAS-7 Invoice

_____ DMAS-93 Invoice _____ DMAS-8 Invoice Adjustment

_____ DMAS-94 Invoice Adjustment _____ DMAS-9 Verification Form

_____ DMAS-659 Envelope

Please return this form to: DMAS Order Desk

Commonwealth/Martin

1700 Venable St.,

Richmond, VA 23223

DMAS-160 R 3/2000

Department of Medical Assistance Services Request for Forms/Brochures

Name _____ Date _____ Telephone # (____)____-_____

Provider Number _____ Contact Person _____

Quantity Form Number Form Name

- _____ DMAS-5 About Your Medicaid Appeal
- _____ DMAS-6B Answers to Your Questions About the Virginia HIV Premium Assistance Prog.
- _____ DMAS-16 Maternity Risk Screen
- _____ DMAS-17 Infant Risk Screen
- _____ DMAS-20 Consent Form for Release of Information
- _____ DMAS-50 Maternal Care Coordinator Record (25/pad)
- _____ DMAS-51 Infant Care Coordinator Record (25/pad)
- _____ DMAS-52 Care Coordination Service Plan (25/pad)
- _____ DMAS-53 Pregnancy Outcome Report (25/pad)
- _____ DMAS-54 Infant Outcome Report (25/pad)
- _____ DMAS-55 Care Coordination Letter of Agreement (25/pad)
- _____ DMAS-70 Practitioner Referral Form
- _____ DMAS-77 ICF/MR Utilization Review Assessment
- _____ DMAS-77A Programs/Objective Continuation Sheet
- _____ DMAS-80 Patient Intensity Rating System review (50/pad)
- _____ DMAS-80A Personal Care Utilization Review
- _____ DMAS-90 Personal Care Aide Record (25/pad)
- _____ DMAS-95 UAI Assessment Process
- _____ DMAS-95A UAI Assessment Process (part A only)
- _____ DMAS-95B UAI Assessment Process (part B only)
- _____ DMAS-95MI/MR Supplemental Assessment Process Form, Page 1
- _____ DMAS-95MI/MR Supplemental Assessment Process Form, Page 2
- _____ DMAS-96 Nursing Home Pre-Admission Screening Plan
- _____ DMAS-97 Plan of Care for Personal Care Services (25/pad)
- _____ DMAS-97A Provider Agency Plan of Care (25/pad)
- _____ DMAS-97B Consumer-Directed Plan of Care
- _____ DMAS-99 Community-Based Care Recipient Assessment Report (25/pad)
- _____ DMAS-99B Consumer-Directed Assessment Report
- _____ DMAS-100 Request for Supervision in Personal Plan of Care (25/pad)
- _____ DMAS-101 MH/MR Service Needs Summary (25/pad)
- _____ DMAS-102 DMAS Private Duty Nursing Plan of Care
- _____ DMAS-103 Monthly Nursing Status Report
- _____ DMAS-113A Medicaid HIV Services Pre-Screening Assessment
- _____ DMAS-113B Medicaid HIV Waiver Services Prescreening Plan of Care
- _____ DMAS-114 AIDS Waiver Authorization Form
- _____ DMAS-115 Nutritional Information Form
- _____ DMAS-119 Social History Form
- _____ DMAS-121 Certificate of Patient Status (50/pad)
- _____ DMAS-121-A Certificate of Patient Rehabilitative Services (50/pad)
- _____ DMAS-122 Patient Information R 12/98 (50/pad)
- _____ DMAS-125 Rehabilitation Treatment Authorization (25/pad)
- _____ DMAS-175 Pharmacist Intervention Report (25/pad)
- _____ DMAS-177 Patient Counseling Log (25/pad)
- _____ DMAS-201 Notification of Medicaid Transportation Denial
- _____ DMAS-212 Title XIX Enrollment (50/pad)
- _____ DMAS-213 Newborn Eligibility Report
- _____ DMAS-216 DMAS-89
- _____ DMAS-300 Respite Care Needs Assessment and Plan of Care
- _____ DMAS-301 Adult Day Health Interdisciplinary Plan of Care
- _____ DMAS-302 Adult Day Health Care Daily Log

Department of Medical Assistance Services Request for Forms/Brochures

Name _____ Date _____ Telephone # (____)____-_____
Provider Number _____ Contact Person _____

Quantity Form Number Form Name

- _____ DMAS-351 Pre-Authorization Request (50/pad)
- _____ DMAS-352 Certification of Medical Necessity
- _____ DMAS-353 EPSDT Medical History Form
- _____ DMAS-353A EPSDT Screening Documentation Form
- _____ DMAS-354 IV Therapy Implementation Form
- _____ DMAS-412 Medicaid Request for Psych. Extension Treatment (25/pad)
- _____ DMAS-420 Request for Hospice Benefits
- _____ DMAS-420A Request For Hospice Benefits(Continued)
- _____ DMAS-421 Hospice Benefits Revocation/Change Statement
- _____ DMAS-500 HIPP Application
- _____ DMAS-501 HIPP Medical History Questionnaire
- _____ DMAS-502 HIPP Employer Verification
- _____ DMAS-503 HIPP Policy Holder Information
- _____ DMAS-750 Fraud Claim Request
- _____ DMAS-751 Notice of Recipient Fraud/Non-Fraud Overissuance
- _____ DMAS-1000 Third Party Liability Information Report
- _____ DMAS-3004 Sterilization Consent Form
- _____ DMAS-3005 Acknowledgement of Receipt of Hysterectomy Information
- _____ DMAS-3006 Abortion Certification R 3/99
- _____ DMAS-4000 Prosthetic Device Preauthorization Form
- _____ DMAS-4001 Physician Certification of Need

Quantity Form Number Brochure Name

- _____ SLH-1 Hospital Brochure
- _____ DMAS-1 EPSDT Pamphlet
- _____ DMAS-2 Virginia Medicaid Handbook
- _____ DMAS-14E MEDALLION Brochure (English)
- _____ DMAS-14S MEDALLION Brochure (Spanish)
- _____ DMAS-60 BabyCare (English)
- _____ DMAS-61 BabyCare (Spanish)
- _____ DMAS-62 BabyCare (Vietnamese)
- _____ DMAS-63 BabyCare (Laotian)
- _____ DMAS-64 BabyCare (Cambodian)
- _____ DMAS-67 Planning Ahead: A Guide for Virginians with Disabilities
- _____ DMAS-250 Intro/State-Funded Long-Term Care System
- _____ DMAS-251 Adult Care Residences
- _____ DMAS-252 AIDS Waiver Services
- _____ DMAS-253 Consumer-Directed Personal Attendant Services
- _____ DMAS-254 Elderly and Disabled Waiver
- _____ DMAS-255 Mental Retardation Waiver
- _____ DMAS-256 Nursing Facility Services
- _____ DMAS-257 Program of All-Inclusive Care for Elderly (PACE)
- _____ DMAS-258 Technology Assisted Waiver
- _____ DMAS 350 Virginia Children's Medical Insurance Plan (CMSIP Handbook)

Quantity Envelope No. Envelope Name

- _____ DMAS-660 Hospital Inpatient/Outpatient
- _____ DMAS-663 CMS-1500 Mailing
- _____ DMAS-89 Personal Care Recipient Admissions
- _____ SLH-24 SLH Mailing

Quantity MISCELLANEOUS NAME

- _____ 3 A Coloring Book for MEDALLION Super Stars
- _____ 10 I was a Good Patient Today
- _____ 11 My MEDALLION Doctor is My Friend
- _____ 12 I'm A MEDALLION Super Star
- _____ 13 My MEDALLION Doctor Said I Did Great

Please return this form to: DMAS Order Desk, Commonwealth/ Martin, 1700 Venable St., Richmond, VA 23223