Section 2 Behavioral Health Electronic CMS-1500 Claim Form Filing Instructions <u>www.emomed.com</u>.

Apply online via the <u>Application for MO HealthNet Internet Access Account</u> link, to utilize the internet for eligibility verification, electronic claim submissions, and RA retrieval. Each user is required to complete this online application to obtain a user ID and password. The application process only takes a few minutes and provides a real-time confirmation response, user ID, and password. Once the user ID and password has been obtained, the user can begin accessing the <u>www.emomed.com</u> website.

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

Any questions regarding the completion of the on-line Internet application, contact the MHD Help Desk at (573) 635-3559.





Welcome to eProvider

Select Claims Management

Select New Claim Select Medical (CMS 1500) form from the drop down list to begin a new claim.

eProvider ePassport We	lcome, Rhonda	Log Out
Home / eProvider / Claim Management		
Claim Management	?	_ 0
NPI		
😨 New Claim 👻 😨 New Xover Claim 👻		
Medical(CMS1500) rch Results		
Outpatient(UB04) Inpatient(UB04) Dental Pharmacy Submitted Charges Dates of Service To Claim Type All Claim Status All Submission Date Submission Date Show My Claims Only Search Clear		
Home Contact Training Search Center Troubleshooting	Y SOCIAL S	ERVICES

NOTE: An asterisk (*) beside field numbers indicate required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

eProvider ePassport		Welcome, Rhonda Log Out
Home / eProvider / Claim Management		
Medical(CMS1500) Claim		? _ 🗆
Billing NPI: M492174503 CORRECTIVE ACTION PAYMENT		
Claim Header Information		-
Participant Information		
Participant DCN *	Participant Last Name *	Participant First Name *
Patient Account Number		
Service Information		
Referring Provider NPI	Hospitalization Dates To	
Service Facility Location	Service Facility Name	
Cause and Diagnosis Details		
Related Cause Codes	Last Menstrual Cycle Date	Diagnosis Codes *
Save Claim Header Reset		
[Q Save claim header to continue. Submit Claim Printer Friendly Reset Can	cel

Claim Header Information	Instructions for completion
Participant's DCN*	Enter the participant's eight-digit MO HealthNet Departmental Client Number (DCN) as shown on the participant's ID card.
Participant's Last Name*	Enter last name as it appears on the participant's ID card.
Participant's First Name*	Enter first name as it appears on the participant's ID card.
Patient Account Number	Enter the participant's account number used by the billing provider's office.
Service Information	Instructions for completion
Referring Provider NPI	Enter the referring physician's MO HealthNet National Provider Identifier (NPI) and Taxonomy code (if applicable). This field is required for independent laboratories and independent radiology groups and physicians

Section 2	CMS-1500 Claim Filing Instruction	August 2018
	with a specialty of " therapy).	30" (radiology/radiation
Hospitalization Dates	If services are provises are provised to be setting, enter the hospitalization.	ded in an inpatient hospital ospital From and To date of Otherwise leave blank.
Service Facility Location	If billing for laborate appropriate value. T not bill for lab work services were provi office/clinic please I The valid values are 77- Service Locatio	ry charges, choose the The referring physician may that was referred out. If ded in the physician's eave blank. e: n
Service Facility Name	If services were ren the home or office, facility. Otherwise, I	dered in a facility other than enter the name of the eave blank.
Cause and Diagnosis De	etails Instructions for co	ompletion
Related Cause Codes	If services on the cl participant's employ other accident, chos the services are not leave blank. The valid values are AA- Auto accident AB- Abuse AP- Another Party F EM- Employment OA- Other accident	aim are related to ment, auto accident or se the appropriate value. If related to an accident, e: Responsible
Last Menstrual Cycle Date	e This field is required prenatal and deliver reflect the last mension	d when billing global ry services. The date should strual period (LMP).
Diagnosis Codes	Enter the complete decimals. The prima secondary diagnosi	diagnosis code(s) without ary diagnosis in Field 1, the s in Field 2, etc.
Save Claim Header	Select Save Claim I the header informat	Header tab to save ion.
Reset / Cancel (claim hea	ider) Select Reset or Car the data from the he	ncel tab to clear all eader.

Section 2

Add Detail Line						
Detail Line Summary	of Service Drocedure Cod	a Modifiere	National Drug Co	ode B	Total Cha	arges : 0.
Add Detail Line #1	of service Procedure Cou	e moumers	National Drug Co	Jue Di	nieu Charges	Action
Dates of Service *	Place of Service *					
10/01/2015 10/01/2	Modifiere			▼		
National Drug Code	Decimal Quantity	(99999999.999)	Pres	cription Number		
Diagnosis Code * - Select One -	Billed Charges *		Days	Units Billed *		
Conditions Emergency EPSDT Family Planning	Performing Provid	er NPI				
Save Detail Line to Claim Reset						
	Q Save De	tail Line to Claim to con	tinue. et Cancel			
Add Detail Line Summ	ary	Instruction	ns for con	npletion		
Date(s) of Service*		Enter the F	rom Date	/ To Date	e of Servic	е.
Place of Service*		Enter the a	ppropriate	place of	service (F	OS)
Noto: Doforonce march	rom onosifia rea			DIIIEU.		
Note: Reference prog	ram specific pro	The volid D	als for app	propriate	POS code	:5.
			Co coues	sale.		
			ss Sheller	S		
		12 Home	–			
		13 Assisted	Living Fa	acility		
		14 Group F	lome			
		21 Inpatien	it Hospital			
		22 Outpatie	ent Hospita	al		
		23 Emerge	ncy Room	I Hospital	l	
		32 Nursing	Facility			
		33 Custodi	al Care Fa	acility		
		50 Federal	ly Qualifie	d Health	Center (FC	(OHC
		51 Inpatien	t Psychiat	ric Facilit	.V	,
		52 Psychia	tric Facility	v Partial I	Hospitaliza	ation
		53 Commu	nity Menta	al Health	Center	
		55 Resider	ntial Subst	ance Abi	ise Trmt. F	acilit
		56 Psychia	tric Reside	ential Tre	atment Ce	nter
		57 Non-Re	sidential S	Substance	- Abuse Tr	rmt
		61 Compre	hensiva Ir	natient F	?ehah Fac	ilitv
		62 Compre	hensive ()utnation(Rehah Fe	acility
		72 Rural L	aalth Clini			Jointy
		$1 \ge 1$ (u) al Π		Schoole		
		OR Schools		SCHOOLS		
) Inlicted Fe	oility (
			THISLEU Pa	Cinty		

Procedure Code*	Enter the appropriate procedure code.
Modifiers**	Enter the applicable modifier, if any, corresponding to the service rendered.
National Drug Code	Procedure Code (Current Procedural Terminology (CPT) / Health Care Procedure Coding System (HCPCS)) entered represents a drug, enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. Enter the 5-4-2 format, if the drug code on the package is not in 5-4-2 format, enter zeros in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.
Decimal Quantity	Procedure Code (CPT/HCPCS) entered represents a drug, enter the decimal quantity dispensed or used in administration, as follows:
	Number of tablets dispensed, Number of grams for ointments or powders. Number of cc's (ml's) administered for solution products (ampule, I.V. bag, bottle, syringe, vial). Number of vials used containing powder for reconstitution. Immunizations and vaccines need to be billed by the ml/cc not by the dosed administered (ampule, I.V. bag, bottle, syringe, vial) Number of Kits administered 1 Kit = 1 unit (Implants, Pegasys, Copaxone)
Prescription Number	Procedure Code (CPT/HCPCS) entered represents a drug, enter the number assigned by the pharmacy, outpatient facility or physician's office or enter a sequential identification number in this field. If the billing provider chooses to use the patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service.

Note: This number is used to sort claims submitted electronically on the remittance advice.

Diagnosis Code*	Select the desired Diagnosis Code.
Billed Charges*	Enter the provider's usual and customary charge per detail line. This should be the total charge if multiple days or units are shown.
Days/Units Billed*	Enter the number of days or units of service provided for detail line.
Conditions	Check the box for service provided involving one or more of the following: Emergency Services; Early and Periodic Screen for Diagnosis and Treatment (EPSDT) of children services; Family Planning services
Performing Provider NPI**	This field is required for a clinic, radiology, teaching institution or group practice only. Enter the Missouri MO HealthNet Provider Identifier (NPI)
Taxonomy Code**	Enter the performing Provider taxonomy code, (if applicable) of the physician or other professional who performed the service.
Save Detail Line to Claim	Select Save Detail Line to Claim tab to save the detail line information. This only saves the current detail line , the claim must still be submitted.

Reset / Cancel (claim detail)

Select Reset or Cancel button to clear the data from the Claim Detail Line section.

Other Payers					Ξ.
Header Summary	r				
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
Add/Edit Details					
Filing Indicator *			V	Payer Responsibility Sequer P - Primary	nce Number *
Other Payer ID * 1		Other Payer Nat Primary Payer	me *	Paid Date *	
Paid Amount * 0.00		Total Denied An 0.00	nount *	Remittance Advice Remark (Codes
Payer at Head	der Level				
Save Other Payer	Data and Manage Codes				
Save Other Pay	er To Claim Reset				

Other Payer Attachment *

Enter the Other Payer (insurance) information reported from the Other Payer Explanation of Benefits (EOB) or the Other Payer (insurance) Remittance Advice

Other Payers					8
Header Summ	ary				
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
Add/Edit Detail	is				
AM - Automol BL - Blue Cro CH - Champu CI - Commerc DS - Disability HM - Health M LI - Liability OF - Other Fe TV - Title V VA - Veteran WC - Workern ZZ - Mutually 99 - Self Pay 10 - Central O 11 - Other No 21 - Preferred 13 - Point of S 14 - Exclusive 5 - Indemnit 16 - Health M MA-Medicare MB-Medicare MC-MO Healt	bile Medical ss/Blue Shield is ial Insurance Co. Maintenance Organization Medical ederal Program Administration Plan 2376 s Compensation Health Cl Defined - Unknown Certification n-Federal Programs 1 Provider Organization (P Service (POS) a Provider Organization (E y Insurance aint Org Medicare Risk thNet	Refers to Veterans Affairs Plar aim PO) PO)	Friendly Reset	Payer Responsibility Seque Paid Date * Remittance Advice Remark	Codes

Filing Indicator*

Select the filing indicator that defines the other payer type.

Other Payers	E Contraction of the second				6
Header Summ	nary				
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
Add/Edit Deta	nils				
Filing Indicate	or *		~	Payer Responsibility Seque	nce Number *
Other Payer I	D *	Other Payer N	ame *	S - Secondary T - Tertiary	
Paid Amount 0.00	•	Total Denied # 0.00	Amount *	A - Payer Responsibility Fo B - Payer Responsibility Fi C - Payer Responsibility Si	ve ix
Payer at F	leader Level			D - Payer Responsibility S E - Payer Responsibility Ei	ght
Save Other Pr	ayer Data and Manage Codes			G - Payer Responsibility Te H - Payer Responsibility F	en
Save Other	Payer To Claim Reset			responsibility C	
		Submit Claim	Printer Friendly Reset	Cancel	

Payer Responsibility Sequence Number *

Other Payer ID*

Indicate which other payer processed the claim. Select primary, secondary, tertiary, etc.

Enter the unique identifier of the other payer as provided on the other payer remittance advice. This field may contain numeric or alphanumeric data up to 20 characters in length.

Note: If not provided, use sequential numbering starting with one (1) for the first payer, two (2) for the second other payer, and etc.

Note: The payer ID in the header must correspond to the payer ID in the detail. For example, if payer has a payer ID of 1234 on the header, must also have a payer ID of 1234 on the detail.

Other Payer Name*	Enter the name of the Other Payer.
Paid Date*	Enter the date the other payer paid.
Paid Amount*	Enter the amount paid including decimals by the Other Payer.
Total Denied Amount**	Enter the total denied amount including decimals processed by the Other Payer.
Remittance Advice Remark Codes	Enter the Health Insurance Portability and Accountability Act (HIPAA) approved X12 remittance remark code reported for this claim on the remittance advice or claim status response received from the other payer.
Payer at Header Level (checkbox)	Check the box if the other payer is at the header level.
Save Other Payer Data	Select Save Other Payer Data to Claim

and Manage Codes

to save the **Header Summary** information.

Line Item(s)	Claim Group Code	Claim Adjustment Reason Code	Adjustment Amount	Actio
Add / Edit Other I	Payer Detail Information			
Associated Line I	tems *			
Claim Group Cod CO - Contractual O CR - Contractual O CR - Contractual O CR - Other Adjustm Pi - Payer Initiated PR - Patient Respon	e * bigations Antonis Reductions sibility	Claim Adjustment Reason Code *	Adjustment Amount *	
- Select One -	×		()	
Save Codes to Ot	her Payer Reset			

Note: The next step is to complete the Group Code, Reason Code, and Adjust Amount for this Payer. The claim must still be submitted.

Associated Line Item (checkboxes)*	Select the appropriate checkboxes to enter the detail lines the other payer codes apply.
Claim Group Code*	Enter the HIPAA- approved X12 adjustment group code assigned by the other payer. If other payer does not use HIPAA- approved

adjustment group codes, you must determine which approved code would be appropriate to submit.

Note: Each adjustment **group code** should be entered if multiple adjustment group codes are reported on the Explanation of Benefits (EOB) or Remittance Advice (RA).

Note: Other Payer adjustments reported to the claim's **total billed** amount at the **header** level **(one total sum)** must be reported on the Other Payer Header.

Note: Other Payer adjustments reported to the claim's **detail line** billed amounts must be reported on the **Other Payer Detail**.

Note: If **both** header and detail line level adjustments were made by the other payer, **both** the Other Payer Header and the Other Payer Detail must be completed.

ONLY approved Health Insurance Portability and Accountability Act (HIPAA) X12 codes are acceptable. These codes can also be found in the <u>HIPAA Related Code List</u> under the Quick Links at <u>http://www.dss.mo.gov/MHD</u>.

Claim Adjustment Reason Code*	Other payer paper remittance advices do not show adjustment reason code for the deductible and coinsurance. Enter "001 " for billing deductible and "002 " for coinsurance. Part C-NON QMB paper remittance advices do not show adjustment reason code for the copay. Enter "003 " for billing copay.
Adjustment Amount*	Enter the Adjustment Amount(s) , including decimals, assigned on the claim by the other payer. The Adjustment Amount(s) is the amount that was NOT paid by the other payer, thus adjusting the reimbursement or covered amount from the submitted charge.
Save Codes to Other Payer	Select Save Codes to Other Payer to save the Codes to Other Payer information to the claim. Note: The claim must still be submitted.
Save Other Payer to Claim	Select Save Other Payer to Claim to save Other Payer to Claim information to the claim. Note: The claim must still be submitted.

Invoice of Cost (click to manage)	
Certificate of Medical Necessity (click to manage)	
Submit Claim Printer Friendly Reset Cancel	

Invoice of Cost Attachment

Complete the Invoice of Cost attachment, If applicable.

nvoice of Cost Details Sumn	nary			
ine Item(s)	Vendor Name	Date of Invoid	e	Action
Add/Edit Invoice of Cost				
laim Line Numbers Associa	ted with Invoice *			
1 2 3				
/endor/Supplier Name *		Date of Invoice *		
dd/Edit Cost Details For Th	is Invoice of Cost			
Cost Details Summary	/			
Item Description	Unit Cost	Total Cost	Cost Type	Action
Add/Edit Cost Details				
Item Description *				
Unit Cost *	Total Cost *		Cost Type *	
			○ MSRP ○ Cost	
Complete Database 10 Press	teret			

Medical Necessity Attachment

Complete the Certificate of Medical Necessity attachment, if applicable.

Certificate of Medical Necessity			1
Medical Necessity Summary			
Line Number/Procedure Code	Description	Reason	Action
Add/Edit Medical Necessity			
- Select One -			
Description *			
Reason *			
Attending/Prescribing Provider Last Name *	Attending/Prescribing Provider First Name	Prognosis	
Attending/Prescribing Provider NPI *	Provider Signature is on File *	Prescription Date *	
Save Med Nec to Claim Reset			
	Submit Claim Printer Friendly Reset Cancel		

Submit Claim	Select Submit Claim to submit the claim.
Printer Friendly	Select Printer Friendly to open the claim in a printer friendly PDF format.
Reset	Select Reset to discard all of the previously entered medical claim information.

Cancel

Select Cancel to discard all of the previously entered medical claim information.

Claim Status			? - 0
🕑 Claim received. 🛐 This claim has a status of K - To	Be Denied, therefore some functions are	not available.	
		Claim Details	
S Void S Replacement	mely Filing 🖓 Copy Claim 👻 🔬 View Cla	aim Details 🔁 Printer Friendly	
Participant Details	Claim Data		Payment Details
Participant Name IMA PATIENT	ICN 4915326000950	Claim Submisson Date 11/22/2015	Total Paid 0.00
Participant DCN 01010101	First Date Of Service 10/01/2015	Last Date of Service 10/01/2015	RA Date
	Claim Type MEDICAL	Bill Type	Check Number
	Total Charges 100.00		
Provider Details	Claim Status Details		
NPI M492174503	Claim Status 33	Category Code F0	Entity Identifier Code
Taxonomy Code	Status Effective Date 11/22/2015	Adjudication Date 11/22/2015	

Claim Status

Processed claim has a status of K to be **Denied**. Processed claim has a status of I to be **Paid**. Processed claim has a status of C -**Captured** claim is still processing. (i.e. attachment, authorization, consultant review) This claim should not be resubmitted until it has a status of I or K.

Internal Control Number (ICN) Number Each processed claim is assigned an ICN.

Electronic CMS-1500 Medicare Professional Crossover Claim Form Filing Instructions



Welcome to eProvider

Select Claims Management

Select New Medicare Crossover Claim Select the appropriate crossover claim type from the drop down list to begin a new crossover claim.



N.	Home	Contact	Training	Search Center	Troubleshooting	9
Provider ePasspo	ort					Welcome, Rhonda Log Out
forme / eProvider /	Claim Manageme	nt				
Claim Manageme	nt					? - 0
NUT						
M492174503	- CORRECTIVE AC	TION PAYMENT	V			
	A					
g New Claim +	g New Xover Clai	m *		Dec. to		
CA	Medicare CMS-15	00 Part B Professional		Results		
	Medicare UB-04 E	OU Part C Professional				
Advanced	Medicare UB-04 P	Part C Institutional				
O Daily Claim 5	Medicare UB-04 P	Part B Professional				
	Medicare UB-04 P	Part C Professional				
Participant DCN	Charges					
Dates of Service	To					
Claim Tune						
All	×					
Claim Status						
All	×					
Submission Date						
Show My Cla	ims Only					
Carr	ch. Churr					
000	Ciear					
Eisish						
rinish						
iome Contact	Training Sea	irch Center Troubles	shooting			SOCIAL SERVICE
						TOPAL SERVICE
are CMS-1500 P	art B Profession	al Claim				?
g NPI: M49217	4503					
RECTIVE ACTION	PAYMENT					
n Header Infor	mation					
icipant Informat	ion					
icipant DCN *		P	articinant Last Name *		Participant First Nam	1e *
		i i	and part East Harris			
ent Account Nui	nber	P	articipant Medicare ID (HIC	C) *		
		L				
rice Information						
icare Provider N	IPI *	H	lospitalization Dates			
			То			
inosis Codes						
gilosis codes ~						
/e Claim Heade	r Reset					
			📿 Save claim hea	ader to continue.		

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Claim Header Information

Instructions for completion

Note: Previous instructions for the Claim Header Information apply to CMS-1500 Medicare Part B and Medicare Part C-QMB Professional claim with the addition of two required fields.

Participant Medicare ID (HIC)* Health Insurance Claim Number Enter the Medicare beneficiary identification number that consists of 9 numbers immediately followed by an alpha suffix.

Medicare Provider NPI*

Enter the Medicare Provider NPI number used to bill this claim to Medicare.

Add Detail Line						
Detail Line Summary						
Line # Date of Service	Place of Service	Procedure Code	Modifiers	National Drug Code	Billed Charges	Action
Add Detail Line #1						
Dates of Service *		Place of Service *				
	То			~		
Procedure Code *		Modifiers				
lational Drug Code		Decimal Quantity (99999	99.999)			
Diagnosis Code * - Select One - 🗸		Billed Charges * 0.00		Days/Units Bill	ed *	
Paid Amount * 0.00		Performing Provider NP	•			
Save Detail Line to Cla	aim Reset					
		📿 Save Detail Lii	ne to Claim to con	tinue.		
		Submit Claim Printer	Friendly Rese	at Cancel		

Add Detail Line Summary

Instructions for completion

Note: Previous instructions for the Add Detail Line Information apply to CMS-1500 Medicare Part B and Medicare Part C- QMB Professional claim.

Performing Provider NPI*

Enter the MO HealthNet Provider Identifier (NPI) / Taxonomy code (if necessary) of the Performing Provider for each detail line.

Other Payers					8
Header Summary					
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
Add/Edit Details					
Filing Indicator * MB-Medicare			~	Payer Responsibility Sequer	v v
Other Payer ID * 1		Other Payer Nan Medicare Part	ne * 3	Paid Date * 10/01/2015	
Paid Amount * 0.00		Total Denied Am 0.00	nount *	Remittance Advice Remark C	Codes
Payer at Head	ler Level				
Save Other Payer	Data and Manage Codes				
Save Other Paye	er To Claim Reset				

Other Payers					8
Header Summa	ary				
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
Add/Edit Detail	ils				
AM - Automot BL - Blue Cro CH - Champu CI - Commerc DS - Disability HM - Health N LI - Liability LM - Liability LM - Liability LM - Liability VA - Veteran. WC - Workers Z2 - Mutually 09 - Self Pay 09 - Self Pay 09 - Self Pay 10 - Central C 11 - Other No 12 - Preferred 13 - Point of S 14 - Exclusive 15 - Indemnity 16 - Health M MA-Medicare MB-Medicare	bile Medical ss/Blue Shield is cial Insurance Co. y Maintenance Organization Medical ederal Program Administration Plan 2376 s Compensation Plan 2376 s Compensation Health Cl Defined - Unknown Certification on-Federal Programs d Provider Organization (P Service (POS) e Provider Organization (E y Insurance laint Org Medicare Risk	Refers to Veterans Affairs Plar laim 'PO) :PO)	n Friendly_Reset	Payer Responsibility Seque	ence Number *

Other Payer Attachment *

Instructions for completion

Note: Previous instructions for the Add Other Payer Header Summary Information apply to CMS-1500 Medicare Part B and Medicare Part C- QMB Professional claim.

Filing Indicator*

Select the filing indicator that defines the type of other payer. For Crossover claims, at least one Other Payer Header Information form must be completed for Medicare with an **MB** (Medicare Part B) or **16** (Medicare Part C-QMB eligible participants only) in this field.

Note: Eligibility benefit of Insurance Type HN **with** QMB indicates Medicare Part C coverage (crossover claim).

Note: Eligibility benefit of Insurance Type HN **without** QMB indicates Medicare Part C coverage (coordination of benefits claims).

Paid Date* Enter the date Medicare payer paid.
Note: Medicare Part B and B of A claims should have at least one group, reason, or adjustment amount at the detail. These claims are paid off of detail only.
Remittance Advice Remark Codes Enter the HIPAA approved X12 remittance remark code reported from this claim on the remittance advice or claim status response received from the other payer.
Payer at Header Level (checkbox) Check the box if the other payer is at the header level.

Other Payer Det	ail Summary			
Line Item(s)	Claim Group Code	Claim Adjustment Reason Code	Adjustment Amount	Actio
Add / Edit Other	Payer Detail Information			
Associated Line	Items *			
1				
Claim Group Co	de *	Claim Adjustment Reason Code *	Adjustment Amount *	
CO - Contractual C	Obligations 🗸	045		
PR - Patient Respo	onsibility 🗸	001		
PR - Patient Respo	onsibility 🗸	002		
- Select One -	~			
Save Codes to O	ther Payer Reset			

Note: If you select a **Group Code**, you must complete the **Reason Code** field and the **Adjustment Amount** field. If you do not have information to enter in these fields, this field should be blank. Adjustment amount of zero is acceptable when appropriate.

MEDICARE ONLY

Part B paper remittance advices do not show an adjustment **group code** for the deductible and coinsurance. Enter group code "**PR**" to report the deductible and coinsurance. Part C paper remittance advices do not show adjustment group code for the copay; enter group code "**PR**" to report the copay.

Claim Adjustment Group Code*	Enter the HIPAA-approved X12 (Medicare) adjustment group code reported for this claim on the remittance advice.
Claim Adjustment Reason Code*	Part B paper remittance advices do not show adjustment reason code for the deductible and coinsurance. Enter " 001 " for billing deductible and " 002 " for coinsurance. Part C paper remittance advices do not show adjustment reason code for the copay. Enter " 003 " for billing copay.
Adjustment Amount*	Enter the Adjustment Amount(s), including decimals, reported for this claim on the remittance advice or claim status response received from Medicare. The Adjustment Amount(s) is the amount that was NOT paid by Medicare, thus adjusting the reimbursement or covered amount from the submitted charge.
	The adjustment amount(s) reflects the difference between the submitted charge and the amount that was paid by Medicare.

When multiple adjustments are reported each adjustment amount should be entered as reported.

	Example: Submitted Charge \$100.00 Medicare Paid \$ 70.00
	Adjustment Amt. \$ 30.00
Save Code to Other Payer	Select Save Code to Other Payer to save the Group code, Reason Code and Adjustment amount information.
Reset / Cancel (Other Payer Detail)	Select Reset/Cancel to clear all entered data from the Other Payer detail form.
Save Other Payer to Claim	Select Save Other Payer to claim to save the Other Payer claim dependent attachment.
Cancel (Other Payer Attachment)	Select Cancel to clear all unsaved data from the Other Payer Attachment.

MEDICARE WITH OTHER PAYER (Insurance) - An Other Payer form must be completed in addition to the Medicare related Other Payer form when there is **another payer** (supplemental insurance) involved.

Other Payers					Ξ
Header Summary					
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
Add/Edit Details					
Filing Indicator *			~	Payer Responsibility Sequen S - Secondary	v v
Other Payer ID * 2		Other Payer Na Other Payer N	me * ame	Paid Date *	
Paid Amount * 0.00		Total Denied Ar 0.00	nount *	Remittance Advice Remark C	Codes
Payer at Header Level					
Save Other Payer Data and Manage Codes					
Save Other Payer To Claim Reset					

Add/Ed	Add/Edit Group Code, Reason Code, Adjust Amount For This Payer				
	Other Payer Detail Summary				
	Line Item(s) Claim Group Code Claim Adjustment Reason Code Adjustment Amount Action				Action
	Add / Edit Other Pay	er Detail Information			
	Associated Line Item	18 *			
	✓ 1				
	Claim Group Code *		Claim Adjustment Reason Code *	Adjustment Amount *	
	OA - Other Adjustments	v	023		
	CO - Contractual Obliga	tions 🗸	045		
	PR - Patient Responsibi	lity 🗸	001		
	PR - Patient Responsibility V 002				
	Save Codes to Other Payer Reset				
Save 0	Save Other Payer To Claim Reset				

Claim Adjustment Group Code*	Enter the HIPAA-approved X12 adjustment group code reported for this claim on the remittance advice or claim status response received from the Other Payer.	
Claim Adjustment Reason Code*	When billing supplemental insurance, you must use a group code/reason code such as OA/023 to report the Medicare Paid Amount. Enter the HIPAA codes assigned by the other insurer or determined to be appropriate such as CO/045 to show any amount that was not paid by the insurer. These amounts must be reported for the claim to process.	
Adjustment Amount(s)*	Enter the adjustment amount(s), including decimals, reported on the HIPAA compliant remittance advice. In the following example \$950.00 is the sum of the adjustment amount(s) for the other payer.	
	Example: Calculation of Other Payer Adjustment Amount billed to Medicare \$2000.00	
	Medicare Paid- \$1000.00	
	\$1000.00	
	Other Payer Paid- \$ 50.00	
	Adjustment Amount \$950.00	
	Payment by MO HealthNet, using the information provided above, and \$110.00 as the deductible amount is shown below.	
	Medicare deductible amount \$110.00 Other payer paid- \$ 50.00	
	MO HealthNet payment amt. \$ 60.00	

ResetISelect Reset to discard Claim Group Codes, Claim Adjustment Reason Codes and Adjustment Amounts which have not previously been saved.Save Other Payer to ClaimSelect Save Other Payer to claim to save the Other Payer claim detail summary.ResetSelect Reset to discard all other payer information entered which has not been previously saved.Cancel (Other Payer Attachment)Select Cancel to clear all unsaved data from the Other Payer Attachment.Submit Claim (tab)Select Printer Friendly to open the claim in a printer friendly PDF format.ResetSelect Reset to discard all of the previously entered medical claim information.Cancel (Other Payer Attachment)Select Cancel to clear all unsaved data from the Other Payer Attachment.Submit Claim (tab)Select Submit Claim to submit the claim.Printer Friendly (tab)Select Reset to discard all of the previously entered medical claim information.CancelSelect Cancel to discard all of the previously entered medical claim information and go back to the Claim Management page.	Save Code to Other Payer	Select Save Code to Other Payer to save the Group code, Reason Code and Adjustment amount information.
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	Cancel	Select Cancel to discard all of the previously entered medical claim information and go back to the Claim Management page.

CMS-1500 Paper Claim Filing Instructions

The Centers for Medicare & Medicaid Services (CMS) -1500 (02-12) claim form should be legibly written or filled out electronically. The <u>Behavioral Health Provider Manual</u> <u>Section 15</u> details the paper claim filling requirements.

MO HealthNet Division (MHD) paper claims should be mailed to the following address:

MO HealthNet Division P.O. Box 5600 Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field	number and name	Instructions for completion
1.	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a.	Insured's I.D.*	Enter the patient's eight-digit MO HealthNet DCN (Departmental Client Number) as shown on the patient's identification card.
2.	Patient's Name*	Enter last name, first name, middle initial <i>in this order</i> as it appears on the patient's ID card.
3.	Patient's Birth Date, Sex	Enter month, day, and year of birth. Mark appropriate box.
4.	Insured's Name**	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

<u>Field</u>	number and name	Instructions for completion
6.	Patient Relationship to Insured**	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.	Insured's Address**	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Reserved for NUCC Use (National Uniform Claim Committ	Leave Blank. ee)
9.	Other Insured's Name**	Enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Field Number 2. If no private insurance is involved leave blank. [See note (1)]
9a.	Other Insured's Policy or Group Number**	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.	Reserved for NUCC Use	Leave Blank
9c.	Reserved for NUCC Use	Leave Blank
9d.	Insurance Plan Name**	Enter the other insured's insurance plan or program name.
		If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.
		If no private insurance is involved, leave blank. [See Note (1)]
10a1	I0c. Is Condition Related to:**	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. [See Note (1)]

Section 2

Field number and name

- 10d. Claim Codes (Designated by NUCC)
- 11. Insured's Group Policy or FECA Number**
- 11a. Insured's Date of Birth, Sex**
- 11b. Other Claim ID** (Designated by NUCC)
- 11c. Insurance Plan Name or Program Name**
- 11d. Other Health Benefit Plan**
- 12. Patient's or Authorized Person's Signature
- 13. Insured's or Authorized Person's Signature**

Leave Blank.

Instructions for completion

Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is

involved, leave blank. [See Note (1)]

Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]

Enter the "Other Claim ID". Applicable claim identifiers are designated by the NUCC.

Enter the primary policyholder's insurance plan name.

If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. [See Note (1)]

Indicate whether the patient has a secondary health insurance plan; if so, complete Field 9, 9a and 9d with the secondary insurance information. If no private insurance is involved, leave blank. [See Note (1)]

Leave blank.

This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance

Field number and name		number and name	Instructions for completion	
			benefits from the policyholder.	
	14.	Date of Current Illness, Injury or Pregnancy**	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).	
	15.	Other Date	Leave blank.	
	16.	Dates Patient Unable to Work	Leave blank.	
	17.	Name of Referring Provider or Other Source**	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1) referring provider; 2) ordering provider; 3) supervising provider.	
			This field is required for independent laboratories and independent radiology groups and physicians with a specialty of "30" (radiology/radiation therapy).	
	17a.	Other ID Number**	The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: OB State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.)	
			This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).	
	17b. I	National Provider Identifier**	Enter the National Provider Identifier (NPI) number of the referring, ordering or supervising provider.	

Field	number and name	Instructions for completion
18.	Hospitalization Dates**	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required when the service is performed on an inpatient basis.
19.	Additional Claim Information (Designated by NUCC)	Providers may use this field for additional remarks/descriptions.
20.	Outside Lab**	If billing for laboratory charges, mark the appropriate box. The referring physician may not bill for lab work that was referred out.
21.	Diagnosis*	Relate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Enter the diagnosis in the same order on all pages of claims with multiple lines. The International Classification of Diseases (ICD) indicator is not used.
22.	Resubmission Code**	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23.	Prior Authorization Number	Leave blank.
24a.	Date of Service*	Enter the date of service under "from" in month/day/year format using the six digit format in the unshaded area of the field. All line items must have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
		The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines is shaded and is the location for reporting

Field	number and name	Instructions for completion
		supplemental information. It is not intended to allow the billing of 12 lines of service.
24b.	Place of Service*	Enter the appropriate place of service code in the unshaded area of the field.
24c.	EMG-Emergency**	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency, leave this field blank.
24d.	Procedure Code*	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.)
24e.	Diagnosis Pointer*	Enter A, B, C, D or the actual diagnosis code(s) from field 21 in the unshaded area of the field.
24f.	Charges*	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.
24g.	Days or Units*	Enter the number of days or units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank.
		<u>Consecutive visits</u> —Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a.
24h.	EPSDT/Family Planning**	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an EPSDT/HCY and Family Planning service enter "B."

<u>Field</u>	number and name	Instructions for completion
24L.	ID Qualifier**	Enter in the shaded area of 24L the qualifier identifying if the number is a non-NPI. The other ID number of the rendering provider should be reported in 24J in the shades area.
24j.	Rendering Provider ID**	The individual rendering the service is reported in this field.
		Enter the NPI number of the provider in the unshaded area of the field.
		This field is required for a clinic, radiology, teaching institution or a group practice only.
25.	Federal Tax ID Number	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	Assignment	Leave Blank.
28.	Total Charge*	Enter the sum of the line item charges.
29.	Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.
30.	Reserved for NUCC Use	Leave Blank.
31.	Provider Signature	Leave Blank.
32.	Service Facility Location Information**	If the services were rendered in a facility other than the home or office, enter the name and location of the facility.
		This field is required when the place of service is other than home or office.

Field number and name	Instructions for completion					
32a. NPI Number**	Enter the NPI number of the service facili location reported in field 32.					
32b. Other ID Number**	Enter number.					
33. Provider Name/ Number /Address*	Affix the billing provider label or write or type the information exactly as it appears on the label.					
33a. NPI Number*	Enter the NPI number of the billing provider listed in field 33.					
33b. Other ID Number**	Enter number.					

- * These fields are mandatory on all CMS-1500 claim forms.
- ** These fields are mandatory only in specific situations as described.
- (1) NOTE: This field is for private insurance information only. If no private insurance is involved, **leave blank**. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.

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