Encounter Clinic Services - Appendices

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Appendix D-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2360 (pdf), Health Insurance Claim Form

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the practitioner.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL letters. The character pitch/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and practitioner signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

A sample of the HFS 2360 (pdf) may be found on the Department's website. Instructions for completion of this claim follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for the form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of practitioner services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Patient's Name** - Enter the participant's name. Separate the components of the name (first, middle initial, last) in the proper order of the name field.
Optional	**2.**	**Patient's Date of Birth** - Enter the month, day and year of birth. Use the MMDDYY format. If the birthdate is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birthdate is not entered, the Department will not attempt corrections. Age – leave blank.
Not Required	3. – 7.	Leave blank.
Required	**8.**	**Medicaid Number** – Enter the nine-digit number assigned to the individual. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Not Required	9.	Other Health Insurance Coverage – Leave blank.
Conditionally Required	**10.**	**Was Condition Related to** – If the patient sought treatment for an injury or illness that resulted from employment, type a capital "X" in the Yes box under A, Patient's Employment. If the patient sought treatment for an injury or a condition that resulted from an automobile accident, type a capital "X" in Field 10B, AUTO. If the place of service billed is for Emergency Department Services, type a capital "X" in Field 10B, OTHER.

Completion	Item	Explanation and Instructions
Not Required	11.	Insured's Address – Leave blank.
Required	**12.**	**Recipient's or Authorized Person's Signature** – The participant or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Not Required	13.	Leave blank.
Conditionally Required	**14.**	**For prenatal services, enter the date of the Last Menstrual Period (LMP).** Use MMDDYY format.
Not Required	15.	Leave blank.
Not Required	16.	Leave blank.
Not Required	17. – 18.	Leave blank.
Conditionally Required	**19.**	**Name of Referring Practitioner or Other Source** – This field is required when charges are being submitted for a **consultation**. Additionally, a referring practitioner's name is always required when a referring practitioner NPI is entered. **Referring Practitioner Number** – The referring practitioner number is always required when a referring practitioner name is entered. Enter the referring practitioner's NPI.
Not Required	20.	Leave blank
Conditionally Required	**21.**	**Facility Where Services Rendered** - This entry is required when Place of Service Code in Field 24B is other than clinic or home. Address may be abbreviated.
Not Required	22.	Leave blank.
Conditionally Required	**23A.**	**Healthy Kids Services** - If services rendered were Healthy Kids services, enter a capital X in the Yes box.
Conditionally Required	**23B.**	**Family Planning** - If services were rendered for family planning purposes, enter a capital X in the Yes box.

Completion	Item	Explanation and Instructions
Conditionally Required	**23C.**	**Sterilization/Abortion** - If services rendered were for a Sterilization or Abortion, enter a capital X in the Yes box. When the service is being submitted for payment for an abortion, a completed copy of the HFS 2390 (pdf) , Abortion Payment Application (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope. When the service is being submitted for payment for sterilization, a completed copy of the HFS 2189 (pdf), Sterilization Consent Form (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope.
Not Required	23D.	Prior Approval – Leave blank.
Required	**23E.**	**T.O.S. (Type of Service)** – Enter the code corresponding to the type of service for which the charges submitted on the claim apply. Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. The following Type of Service codes are to be used: 1 Medical Care – Attending Physician 2 Surgery – Surgeon 3 Consultation - Consultant
Optional	**23F.**	**Diagnosis or Nature of Injury or Illness** – Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient's treatment. A written description is not required if a valid ICD-9-CM Code or ICD-10 code is entered in Item 24D.
Optional	**24.**	**Repeat** – The repeat indicator may be used to complete the same data fields in multiple service sections. All information other than the date of service must remain the same as the previous service section. The actual date of service must be entered in every service section. When the repeat box is necessary, enter a capital "X." Any other character will be ignored. The repeat indicator cannot be used immediately following a service section which has been deleted.

Completion	Item	Explanation and Instructions
Required	**24A.**	**Date of Service** - Enter the date the service was rendered. Use MMDDYY format. Encounter Clinics are limited to one date of service per claim.
Required	**24B.**	**P.O.S. (Place of Service)** – Enter the 2-digit Place of Service Code appropriate for the particular service. The acceptable place of service codes are 12, 31, 32, 33, 49, 50 and 72.
Required	**24C.**	**Procedure Code/Drug Item No.** – When billing for an Encounter, enter the appropriate encounter procedure code in Service Section 1 of the claim. In Service Sections 2 through 7 of the claim, enter the appropriate CPT, NDC or HCPCS procedure codes for the services rendered during the encounter. Detail lines are mandatory. If more than one claim is required to identify detail services, Service Section 1 of the additional claims must always contain the encounter code.
Conditionally Required	**24C.**	**MOD** – Enter the appropriate two-character modifier for the service performed. This entry is required when the encounter billed is for behavioral health, family planning, EPSDT, telehealth, and private stock vaccines.
Required	**24D.**	**Primary Diagnosis Code** – Enter the specific ICD-10 code without the punctuation or spaces for the primary diagnosis.
Optional	**24D.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered. Enter only a specific ICD-10 code without the punctuation or spaces.
Required	**24E.**	**Charges** – When billing an encounter, enter the clinic's unique encounter rate in Service Section 1. In Service Sections 2 through 7, enter either 0.00 or the clinic's usual and customary charges. When billing a private stock vaccine as part of an encounter or FFS, a usual and customary rate is required. When billing FFS, bill the acquisition rate or the usual and customary rate.
Required	**24F.**	**Days/Units** – Enter the appropriate number of units in the detail service sections. For the Department's quantity limitations, refer to the practitioner fee schedule.
Optional		**Delete** - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	**25.**	**Signature of Physician and Date Signed** - After reading the certification statement printed on the back of the claim form, the provider or authorized biller (provider's name followed by biller's initials) must sign the completed form. **The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable.** Unsigned claims will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered in the MMDDYY format. The provider's signature should not enter the date section of this field.

Completion	Item	Explanation and Instructions
Required	**26.**	**Accept Assignment** – The practitioner must accept assignment of Medicare benefits for services provided to participants. Enter a capital “X” in the "Yes" box.
Required	**27.**	**Total Charges** - Enter the sum of all charges submitted on the claim in service section 1 through 7. Do not include charges for any deleted sections.
Required	**28.**	**Amount Paid** - Enter the sum of all payments received from other sources. The entry must equal the sum of the amounts as shown in fields 37C and 38C, TPL Amount. If no payment was received enter three zeroes (000). Do not collect primary copayments on Medicaid secondary claims. Do not include HFS copayments or amount previously paid by the Department as primary payment.
Required	**29.**	**Balance Due** - Enter the difference between Total Charges and Amount Paid.
Required	**30.**	**Your Provider Number** - Enter the provider’s **NPI**.
Required	**31.**	**Provider Name, Address, ZIP Code** – Enter the clinic’s name exactly as it appears on the Provider Information Sheet. Enter the street address of the clinic. If an address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If an address is not entered, the Department will not attempt to make corrections. Enter city, state and zip code of clinic.
Optional	**32.**	**Your Patient's Account Number** - Enter up to 20 numbers or letters used in your accounting system for identification. If this field is completed, the same data will be reported on the HFS 194-M-2, Remittance Advice.
Required	**33.**	**Your Payee Number** – Enter the one-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**34.**	**Number of Sections** - Enter the number of service lines correctly completed above in Section 24. Do not include **deleted** sections.
Not Required	35. - 36.	Leave blank.

Completion	Item	Explanation and Instructions
Conditionally Required	**37A.**	**TPL Code** – If the patient's has a TPL , the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in 38A. – 38D. **Do not attach a copy of the TPL Explanation of Benefits (EOB).** Practitioners providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a patient's private insurance carrier prior to billing the Department for these services. **Do not report Medicare Information in the TPL fields.** Refer to Appendix A-2 for information regarding Medicare crossovers. For Medicare denied services with an additional TPL resource involved, please report the following: • Do not report the Medicare information in the TPL field. • Do attach a copy of the Medicare EOB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOB. **Spenddown** – Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant liability as shown on the HFS 2432 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required	**37A. (cont.)**	If the HFS 2432 shows a participant liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 01 TPL Amount the actual participant liability up to total charges TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.

Completion	Item	Explanation and Instructions
Conditionally Required	**37B.**	**TPL Status** – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the practitioner is advised **by the third party resource** that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the practitioner is advised **by the third party resource** that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**37C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Completion	Item	Explanation and Instructions
Conditionally Required	**37D.**	**TPL Date** – A TPL date is required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status Code: **Code** **Date to be entered** 01 Third Party Adjudication Date 02 Third Party Adjudication Date 03 Third Party Adjudication Date 04 Date from the HFS 2432, Split Bill Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Conditionally Required	**38A.**	**TPL Code** – (See 37A above).
Conditionally Required	**38B.**	**TPL Status** – (See 37B above).
Conditionally Required	**38C.**	**TPL Amount** – (See 37C above).
Conditionally Required	**38D.**	**TPL Date** – (See 37D above).

Mailing Instructions

The Health Insurance Claim Form is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part form should be removed prior to submission to the Department. The provider should retain a copy of the claim.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as Medicare denial EOMB or HFS 2432, Split Billing Transmittal submitted with a one page claim) are to be mailed to the Department in pre-addressed mailing envelope, HFS 1414, Special Approval Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Non-routine claims (multiple claims submitted with a HFS 2432, Split Billing Transmittal)are to be mailed to the Department for special handling.

Mailing address: Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115

Forms Requisition - Billing forms may be requested on our website or by submitting a HFS 1517 (pdf) as explained in Chapter 100.

Appendix D-2

Technical Guidelines for Paper Claim Preparation
Form HFS 3797, Medicare Crossover Invoice

To assure efficient processing by the Department, please follow these guidelines in the preparation of paper claims for image processing:

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the practitioner.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the practitioner.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and practitioner signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- Print in the gray area of attachments, either as part of the original or as a result of photocopying a colored background, is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to the back of the claims. Do not fold claims or fasten attachment with staples.

Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797. A sample of the HFS 3797 (pdf) may be found on the Department's website. Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form and attach the Explanation of Medicare Benefits to the claim.** Refer to Appendix D-1 for billing and mailing information.

The left hand column of the following instructions identifies mandatory and optional items for the form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Completion	Item	Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the appropriate box, using the following guideline when determining claim type: 23 - Practitioner – physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers 24 - Dental – dental providers 25 - Lab/Port X-Ray – all laboratories and portable X-ray providers 26 - Med. Equip/Supply – medical equipment and supply providers, pharmacies 28 - Transportation – ambulance service providers If provider type is not indicated above, enter a capital "X" in the Practitioner box.
Required	**1.**	**Recipient's Name** - Enter the participant s name (first, middle, last)
Required	**2.**	**Recipient's Birthdate** - Enter the month, day and year of birth. Use the MMDDYY format.
Required	**3.**	**Recipient's Sex** – Enter a capital "X" in the appropriate box.

Completion	Item	Explanation and Instructions
Conditionally Required	**4** **A.** **B.**	**Was Condition Related to** – Recipient's Employment - Treatment for an injury or illness that resulted from participant's employment, enter a capital "X" in the "Yes" box. Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate. Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.
Required	**5.**	**Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number from the Identification Card or Notice. Do not use the Case Identification Number.
Required	**6.**	**Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).
Required	**7.**	**Recipient's Relation to Insured** – Enter a capital "X" in the appropriate box.
Required	**8.**	**Recipient's or Authorized Person's Signature** – The participant or authorized representative must sign and enter a date unless the signature is on file with the provider/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Conditionally Required	**9.**	**Other Health Insurance Information** - If the participant has an additional health benefit plan (other than Medicare or Medicaid), enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.
Required	**10A.**	**Date(s) of Service** - The "From" date is the only date necessary to complete. Using the MMDDYY format
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the 2-digit Place of Service Code submitted to Medicare.

Completion	Item	Explanation and Instructions
Required	**10C.**	**T.O.S. (Type of Service)** – Enter the code corresponding to the type of service for which the charges submitted on the claim apply. Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. The following Type of Service codes are to be used: 1 Medical Care – Attending Physician 2 Surgery – Surgeon 3 Consultation - Consultant
Required	**10D.**	**Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001. Anesthesia or Assistant Surgery Services – Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 0001.
Required	**10E.**	**Procedure Code** – Procedure code T1015 is the only procedure code that should be billed. **No detail coding is to be reported, including NDCs and HCPCS codes.**
Required	**10F.**	**Amount Allowed** – Identify the "per diem rate" as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10G.**	**Deductible** – Identify the dollar amount applied to the patient's deductible as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Identify the dollar amount designated as the patient's coinsurance as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Identify the net reimbursement as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	11.	For NDC Use Only

Completion	Item	Explanation and Instructions
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	13A.	Origin of Service – Leave blank.
Not Required	13B.	Modifier – Leave blank.
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.
Not Required	15A.	Origin of Service – Leave blank.
Not Required	15B.	Modifier – Leave blank.
Not Required	16A.	Destination of Service – Leave blank.
Not Required	16B.	Modifier – Leave blank.
Required	**17.**	**ICN #** - Enter the Medicare Invoice Control Number.
Conditionally Required	**18.**	**Diagnosis or Nature of Injury or Illness** - Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-9-CM code or ICD-10 code, is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the valid ICD-9-CM code ICD-10 code upon implementation, without punctuation or spaces for the services rendered.
Optional	**18B.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-9-CM code or ICD-10 code, without punctuation or spaces.
Required	**19.**	**Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.
Conditionally Required	**20.**	**Name and Address of Facility Where Services Rendered** –This entry is required when Place of Service (10B) is other than provider's office or participant's home. Enter the facility name and address where the service(s) was rendered. When the name and address of the facility where the services were rendered is the same as the biller's name and address as submitted in Field 22, enter the word "Same."

Completion	Item	Explanation and Instructions
Required	**21.**	**Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to participant s for the Department to consider payment of deductible and coinsurance amounts. Enter a capital “X” in the "Yes" box.
Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the practitioner/supplier name exactly as it appears on the Provider Information Sheet to the right of the “Provider Key.”
Required	**23.**	Enter the rendering provider’s NPI.
Required	**24.**	**Payee Code** – Enter the single digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Conditionally Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the referring or ordering practitioner if the service or item was ordered or referred by a practitioner. Referring Practitioner – a practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Practitioner – A practitioner who orders non-physician services for the participant such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a practitioner’s order or referral must include the ordering/referring practitioner’s NPI.
Not Required	27.	Medicare Provider ID Number – Leave blank.
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy Code. Refer to Chapter 300, Appendix 5.

Completion	Item	Explanation and Instructions
Conditionally Required	**29A.**	**TPL Code** – If the patient has a TPL, the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in Fields 30A – 30D. **Do not report Medicare information in the TPL fields.** **Spenddown** – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant liability as shown on the HFS 2432 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 01 TPL Amount the actual participant liability up to total charges TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required	**29A. (cont.)**	Claim 2 TPL Code 906 TPL Status 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.

Completion	Item	Explanation and Instructions
Conditionally Required	**29B.**	**TPL Status** – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the practitioner is advised **by the third party resource** that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the practitioner is advised **by the third party resource** that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**29C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Completion	Item	Explanation and Instructions
Conditionally Required	**29D.**	**TPL Date** – A TPL date is required when any status code is shown in Field 29B. Use the date specified below for the applicable TPL Status Code. Use the MMDDYY format. **Status Code Date to be entered** 01 Third Party Adjudication Date 02 Third Party Adjudication Date 03 Third Party Adjudication Date 04 Date from the HFS 2432, Split Billing Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Conditionally Required	**30A.**	**TPL Code** – (See 29A above).
Conditionally Required	**30B.**	**TPL Status** – (See 29B above).
Conditionally Required	**30C.**	**TPL Amount** – (See 29C above).
Conditionally Required	**30D.**	**TPL Date** – (See 29D above).
Required	**31.**	**Provider Signature** - After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black or blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the provider. The provider's signature should not enter the date section of this field.
Required	**32.**	**Date** – The date of the provider's signature is to be entered in the MMDDYY format.

Mailing Instructions

The Medicare Crossover Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part form should be removed prior to submission to the Department. The provider should retain the yellow copy of the claim.

Routine claims are to be mailed to the Department in the pre-addressed mailing envelopes, HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department. If envelopes are not available, the HFS 3797 can be mailed to:

Mailing address: Medicare Crossover Invoice
Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Non-routine claims (multiple claims submitted with an HFS 2432, Split Bill Transmittal) must be mailed to the Department for special handling.

Mailing address: Healthcare and Family Services
PO Box 19115
Springfield, Illinois 62794-9115

Do not bend or fold claims prior to submission. Do not attach EOMB to claim.

Forms Requisition - Billing forms may be requested on our website or by submitting a HFS 1517 (pdf) as explained in Chapter 100.

Appendix D-3

Telehealth Billing Examples

Billing Examples for Telemedicine Services

Example 1: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s)
Reimbursement will be the facility's medical encounter rate

Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider

Example 2: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s)
Reimbursement will be the facility's medical encounter rate

Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider

Example 3: **Originating Site – Physician's office**
Bill HCPCS Code Q3014
Reimbursement is $25.00

Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s)
Reimbursement will be the facility's medical encounter rate. The rendering provider's name and NPI must also be reported on the claim

Billing Examples for Telepsychiatry Services

Example 1: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s)
Reimbursement will be the facility's medical encounter rate

Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program

Example 2: **Originating Site – Physician's office**
Bill HCPCS Code Q3014
Reimbursement will be $25.00

Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s)
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program
Reimbursement will be the facility's medical encounter rate

Example 3: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s)
Reimbursement will be the facility's medical encounter rate

Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program

Appendix D-4

Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately via IMPACT.

Provider change information can be communicated to the Department via the on-line application available on the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) Provider Enrollment webpage. The on-line change function is available to notify the Department of updates or changes to enrollment information for the following categories:

- National Provider Identifier (NPI)
- Provider name
- Provider demographic (address, phone, email)
- Payee demographic (address, phone, email)
- Add a Pay To (payee)
- Close a Pay To (payee)
- Close enrollment
- License
- Clinical Laboratory Improvements Amendments (CLIA)

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix D-4a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI.
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** Code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative, which indicates the provider's classification.

	Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Individual Practice 02 = Partnership 03 = Corporation
Enrollment Specifics	**Enrollment Status** is a one-digit code and corresponding narrative, which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field. Contact the Provider Enrollment Services to reactive enrollment if the enrollment status is "I". **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A - Exception Requested by Audits C - Citation to Discover Assets G - Garnishment T - Tax Levy If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** is the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank. **AGR** (Agreement) indicates whether the provider has agreed to the Terms & Conditions in IMPACT. If the value of the field is yes, the provider is eligible to submit claims electronically.
Certification/License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.

Categories of Service	This area identifies special licensure information and the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are: 026 – Encounter Rate Clinic Services 030 – Healthy Kids Screening Services 058 – Social Worker 059 – Psychologist 088 – Licensed Clinician – LCPC/LMFT 102 – Fluoride Varnish for Children under 36 months 104 – Family Planning Device, FFS Each entry is followed by the date that the provider was approved to render services for each category listed.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.** **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes. Therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
NPI	The National Provider Identification Number contained in the Department's database.
Signature	The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services. Stamped signatures are not acceptable.

Appendix D-4a
Reduced Facsimile of Provider Information Sheet

```
                                          STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS)                  HEALTHCARE AND FAMILY SERVICES                RUN DATE: 1/10/09
PROVIDER SUBSYSTEM                                                                    RUN TIME: 11:47:06
REPORT ID:  A2741KD1                        PROVIDER INFORMATION SHEET              MAINT DATE: 1/10/09
SEQUENCE:   PROVIDER TYPE                                                                 PAGE:    84
          PROVIDER NAME

- -PROVIDER KEY- -
    333333333001
```

PROVIDER NAME AND ADDRESS
ABC Clinic
1441 MY STREET
ANYTOWN, IL 62222-2222

PROVIDER GENDER:
COUNTY 200-COOK
TELEPHONE NUMBER 888-123-4567

PROVIDER TYPE: 040 – FQHC
ORGANIZATION TYPE: 02 – CORP PRACT
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/01/06 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – ENDING
PHARMACY AFFIL: CLIA #:
LAST TRANSACTION ADD AS OF 01/14/09
NCPDP #:

D.E.A.#:
RE-ENROLLMENT INDICATOR: E DATE: 11/15/07

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

CODE	PROCEDURE DESCRIPTION	BEGIN	CURRENT RATE
T1015	CLINIC VISIT/ENCOUNTER	05/01/09	$100.00

ELIG COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	TERMINATION BEG DATE	REASON
026	CLINIC SERVICES	05/01/09				
030	HEALTHY KIDS SCREENING SERVICES	05/01/09				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ABC Clinic	1441 MY STREET	ANYTOWN	IL	62222	333333333-62222-01		05/01/09
	DBA:					TIN #: 01		

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
1112223338

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

Appendix D-5
Internet Quick Reference Guide

The Department's handbooks are designed for use via the Internet and contain hyperlinks to the pertinent information.

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Claims Processing System Issues
Child Support Enforcement
Dental Program
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
Place of Service Codes
Centers for Medicare and Medicaid Services (CMS)

Appendix D-6

Vaccine Billing Instructions
Encounter Rate Clinics Only

Children 0 through 18 years of age (Title XIX [19] Only)

Clinics should bill the VFC vaccine as part of a billable visit with the medical encounter procedure code, T1015, or bill the VFC vaccine with the Wellness Visit procedure code, S5190, when a child presents solely for the injection. When billing a private stock vaccine as part of an encounter or fee-for-service, clinics must enter a rate as a provider charge.

Example #1
A Well-Child examination and routine VFC vaccinations are administered in an encounter rate clinic setting. The exam meets the definition of a billable encounter.

- 1st service line, bill the T1015, medical encounter rate procedure code.
- 2nd service line, bill the appropriate level evaluation and management procedure code.
- Subsequent service line(s), bill the specific VFC vaccine procedure code(s).

Procedure Code	Description	Reimbursement Rate
T1015	All-inclusive clinic/visit medical encounter	Provider specific medical encounter rate
99xxx	Evaluation and Management Code	$0
90xxx	Specific VFC-provided vaccine	$0

Example #2
A Well-Child examination and routine VFC vaccines and private stock vaccines (not offered through VFC) are administered in an encounter rate clinic setting. The exam meets the definition of a billable encounter.

- 1st service line, bill the T1015, medical encounter rate procedure code.
- 2nd service line, bill the appropriate level evaluation and management procedure code.
- 3rd service line, bill the specific VFC vaccine procedure code.
- 4th service line, bill the private stock vaccine procedure code with the ***GB*** modifier for vaccines not offered through VFC.

Procedure Code	Description	Reimbursement Rate
T1015	All-inclusive clinic/visit medical encounter	Provider-specific~~s~~ medical encounter rate
99xxx	Evaluation and Management Code	$0
90xxx	Specific VFC-provided vaccine	$0
90xxx with ***GB*** modifier	Specific private stock vaccine	Per fee schedule ***State Max*** field

Example #3
A patient presents solely to receive a VFC vaccine at an encounter rate clinic. A salaried staff member administers the VFC vaccine. The visit does not qualify as a billable encounter.

- 1st service line, bill the S5190, Wellness Assessment encounter procedure code.
- 2nd service line, bill the specific VFC vaccine procedure code as detail procedure code.

Procedure Code	Description	Reimbursement Rate
S5190	Wellness Assessment, performed by Non-Physician	$0
90xxx	Specific VFC-provided vaccine	$0

EXAMPLE #4
A patient presents solely to receive a routine private stock vaccine at an encounter rate clinic when a vaccine is not offered through VFC. A salaried staff member administers the vaccines. The visit does not qualify as a billable encounter.

- Bill the private stock vaccine procedure code with the ***GB*** modifier.

Procedure Code	Description	Reimbursement Rate
90xxx with ***GB*** modifier	Specific private stock vaccine	Per fee schedule ***State Max*** field

Children 0 through 18 years of age (Title XXI [21] & State-Funded)
And Adults +19 years of age

Effective 10/1/2016, clinics must bill private stock vaccine procedure codes with the ***GB*** modifier when administered as part of a billable visit with the encounter procedure code or when the participant presents solely to receive a vaccine at the clinic.

- Shots and immunizations are considered *direct access services* and do not require a referral. Refer to the Illinois Health Connect Primary Care Provider Handbook.

EXAMPLE #5
A Well-Child examination and routine private stock vaccinations are administered in an encounter rate clinic setting. The exam meets the definition of a billable encounter.

- 1st service line, bill the T1015, medical encounter rate procedure code.
- 2nd service line, bill the appropriate level evaluation and management procedure code.
- 3rd service line, bill the private stock vaccine procedure code & ***GB*** modifier.

Procedure Code	Description	Reimbursement Rate
T1015	All-inclusive clinic/visit medical encounter	Provider specific medical encounter rate

99xxx	Evaluation and Management Code	$0
90xxx w modifier ***GB***	Specific private stock vaccine	Per fee schedule ***State Max*** field

Example #6
A patient presents solely to receive a routine private stock vaccine at an encounter rate clinic. A salaried staff member administers the vaccine. The visit does not qualify as a billable encounter.

- Bill the specific private stock vaccine procedure code with the ***GB*** modifier.

Procedure Code	Description	Reimbursement Rate
90xxx w modifier ***GB***	Specific private stock vaccine	Per fee schedule ***State Max*** field