Optometric Services - Appendices

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Appendix O-1

Technical Guidelines for Paper Claim Preparation
Form HFS 1443, Provider Invoice

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 provider.
- 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.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use black or dark blue ink for entries on the billing form, attachments and provider 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.

Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. A sample of the HFS 1443 may be found on the Department's website.

The left hand column of the following instructions identifies mandatory and optional items for 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 provider services.

Completion	Item	Item Explanation and Instructions
Required	**1.**	**Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** - Enter the National Provider Identifier (NPI) number.
Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Not Required	4.	Role – Leave Blank.
Not Required	5.	Emer – Leave Blank.
Not Required	6.	Prior Approval – Leave Blank
Optional	**7.**	**Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider errors. If address is not entered, the Department will not attempt corrections.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**8.**	**Facility and City Where Service Rendered** – This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office).
Optional	**9.**	**Provider City State ZIP** – Enter city, state and ZIP code of provider. See item 7 above.
Not Required	10.	Referring Practitioner Name – Leave blank.
Required	**11.**	**Recipient Name** – Enter the patient's name. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required	**12.**	**Recipient Number** - Enter the nine-digit number assigned to the individual. Do not use punctuation or spaces. Do not use the Case Identification Number.
Optional	**13.**	**Birth Date** – Enter the month, day and year of birth of the patient. Use the MMDDYY format. If the birth date is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birth date is not entered, the Department will not attempt corrections.
Not Required	14.	H Kids – Leave Blank
Not Required	15.	Fam Plan – Leave Blank.
Not Required	16.	St/Ab – Leave Blank.
Required	**17.**	**Primary Diagnosis Description** - Enter the primary diagnosis that describes the condition primarily responsible for the patient's treatment.
Required	**18.**	**Primary Diag. Code** - Enter the specific ICD-10 without the decimal for the primary diagnosis described in Item 17.
Required	**19.**	**Taxonomy** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to the Taxonomy for 837P table in Chapter 300.

Completion	Item	Item Explanation and Instructions
Optional	**20.**	**Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form 194-M-2, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. – Leave blank.
Not Required	22.	Secondary Diagnosis Code – Leave Blank.
	23.	**Service Sections** – Complete one Service Section for each item or service provided to the patient.
Required		**Procedure Description/Drug Name, Form and Strength or Size** – Enter the description of the service provided or item dispensed.
Required		**Proc. Code/NDC** – Enter the appropriate CPT or HCPCS code.
Not Required		Modifiers
Required		**Date of Service** – Enter the date the service was provided. Use the MMDDYY format.
Required		**Cat. Serv.** – Enter the appropriate two-digit category of service code. 03 Optometric Services 45 Optometric Supplies
Conditionally Required		**Delete** – When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only the "X" will be recognized as a valid character; all others will be ignored.

Completion	Item	Item Explanation and Instructions
Required	**23. cont'd**	**Place of Serv.** – Enter the two-digit Place of Service code from the following list: 11 – Office 12 – Home 13 – Assisted Living Facility 14 – Group Home 31 – Skilled Nursing Facility 32 – Nursing Facility 33 – Custodial Care Facility
Not Required		Units/Quantity – Leave blank.
Not Required		Modifying Units – Leave Blank.
Conditionally Required		**TPL Code** - The patient's TPL code is to be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the three-digit TPL code. If more than one third party made a payment for a particular service or item, the additional payment(s) are to be shown in Section 25. **Do not report Medicare Information in the TPL fields.** Refer to Appendix O-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 EOMB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOMB.

Completion	Item	Item Explanation and Instructions
	23. cont'd	**TPL Entries for 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. If the HFS 2432 shows a participant liability 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.

Completion	Item	Item Explanation and Instructions
	23. cont'd	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	Item Explanation and Instructions
Conditionally Required	**23. cont'd**	**Status** - If a TPL code is shown in the preceding item, 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 provider 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 provider is advised by the third party resource that the services provided are not covered. **04 - TPL Adjudicated - spenddown met**: TPL status code 04 is to be entered when the patient's Form HFS 2432, Split Billing Transmittal, shows $0.00 liability. **05 - Patient not covered**: TPL Status Code 05 is to be entered when the patient informs the provider that the third party resource identified is not in force. **06 - Services not covered**: TPL Status Code 06 is to be entered when the provider 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, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 - Deductible not met**: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**23. cont'd**	**TPL Amount** - Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other Status Codes, enter 0 00. If there is no TPL code, no entry is required.
Conditionally Required		**TPL Date** - A TPL date is required when any status code is shown in the TPL Status item. Use the date specified below for the applicable 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 05 — Date of Service 06 — Date of Service 07 — Date of Service 10 — Third Party Adjudication Date
Required		**Provider Charge** - Enter the total charge for the service, not deducting any third party liability.
Not Required	24.	Optical Materials Only – Leave Blank. **Note:** When ordering lenses and/or frames, complete Form HFS 2803, Optical Prescription Order. Attach the HFS 2803 to the HFS 1443 Provider Invoice and submit both forms to the Department.

Sections 25 through 30 of the Provider Invoice are to be used: 1) To identify additional third party resources in instances where the patient has access to two or more resources and 2) To calculate total and net charges.

If an additional third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions.

Conditionally Required	**25.**	**Sect. #** - If more than one third party made a payment for a particular service, enter the Service Section number (1 through 6) in which that service is reported. If a third party made a single payment for several services and did not specify the amount applicable to each, enter the Number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 25C will be applied to the total of all Service Sections on the Provider Invoice.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**25A.**	**TPL Code** – Enter the appropriate TPL code referencing the source of payment. If the TPL Codes are not appropriate, enter Code 999 and enter the name of the payment source in Item 35.
Conditionally Required	**25B.**	**Status** – Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.
Conditionally Required	**25C.**	**TPL Amount** – Enter the amount of payment received from the third party resource.
Conditionally Required	**25D.**	**TPL Date** – Enter the date the claim was adjudicated by the third party resource. See the TPL Date field in Item 23 above for correct coding of this field.
Conditionally Required	**26.**	**Sect #** - Enter (see 25 above).
Conditionally Required	**26A.**	**TPL Code** – (See 25A above).
Conditionally Required	**26B.**	**Status** – (See 25B above).
Conditionally Required	**26C.**	**TPL Amount** – (See 25C above).
Conditionally Required	**26D.**	**TPL Date** – (See 25D above).
Conditionally Required	**27.**	**Sect.** – (See 25 above).
Conditionally Required	**27A.**	**TPL Code** – (See 25A above).
Conditionally Required	**27B.**	**Status** – (See 25B above).
Conditionally Required	**27C.**	**TPL Amount** – (See 25C above).
Conditionally Required	**27D.**	**TPL Date** – (See 25D above).

Completion	Item	Item Explanation and Instructions
Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.		
Required	**28.**	**Tot Charge** – Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
Required	**29.**	**Tot Deductions** – Enter the sum of all payments submitted in the TPL Amount field in Service Sections 1 through 6. If no payment was received, enter zeroes (0 00).
Required	**30.**	**Net Charge** – Enter the difference between Total Charge and Total Deductions.
Required	**31.**	**# Sects** – Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections that were deleted because of errors.
Not Required	32.	Original DCN – Leave Blank.
Not Required	33.	Sect. – Leave Blank.
Not Required	34.	Bill Type - Leave Blank.
Conditionally Required	**35.**	**Uncoded TPL Name** – Enter the name of the third party resource. The name must be entered if TPL code 999 is used.
Required	**36-37.**	**Provider Certification, Signature and Date** – After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned Invoices will be rejected. The signature date must be entered in MM/DD/YY format.

Mailing Instructions

The HFS 1443 Provider 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 continuous feed form should be removed prior to submission to the Department. The copy of the claim is to be retained by the provider.

Routine claims, including those with an HFS 2803 Optical Prescription Order attached, are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1444, Provider Invoice Envelope, provided by the Department.

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

Non-routine claims (claims with attachments, such as EOB or HFS 2432 Split Billing Transmittal) are to be mailed to the Department in pre-addressed mailing envelope, Form 2248, NIPS Special Handling Envelope, which is provided by the Department for this purpose.

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

Forms Requisition: Billing forms may be requested on the website at the Medical Provider Forms Request page, or by submitting a HFS 1517, as explained in Chapter 100.

Appendix O-2

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

To assure the most 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 provider.
- 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 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 black or dark blue ink for entries on the billing form, attachments and provider 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.

Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797. A sample of Form HFS 3797 Medicare Crossover Invoice 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 HFS 1443 claim form.** Refer to Appendix O-1 for billing and mailing information.

The left hand column of the following instructions identifies mandatory and optional items for 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 claim 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	Item Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the box labeled 23 – Practitioner (includes physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers).
Required	**1.**	**Recipient's Name** - Enter the participant's name (first, middle, last).
Required	**2.**	**Recipient's Birth date** - 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	Item Explanation and Instructions
Conditionally Required	**4.**	**Was Condition Related to** – **A.** Recipient's Employment - Treatment for an injury or illness that resulted from participant's employment, enter a capital "X" in the "Yes" box. **B.** 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. 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 "Self" 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, 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** - Enter the date(s) of service submitted to Medicare. Use MMDDYY format in the "From" and "To" fields.
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.
Required	**10C.**	**T.O.S. (Type of Service)** – Refer to the Handbook for Practitioners Rendering Medical Services appendices for a listing of valid TOS codes.

Completion	Item	Item Explanation and Instructions
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. Mileage – Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032. 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** - Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
Required	**10F**.	**Amount Allowed** – Enter the amount allowed by Medicare for the item(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10G.**	**Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Enter the amount the provider was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Conditionally Required	**11.**	**For NDC Use Only** - Required when billing NDC codes for pharmacy/physician claims.
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS 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.

Completion	Item	Item Explanation and Instructions
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.
Optional	**17.**	**ICN #** - Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on Form HFS 194-M-2, Remittance Advice, returned to the provider.
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.
Required	**18A.**	**Primary Diagnosis Code** – Enter the appropriate diagnosis code without the decimal for the primary diagnosis described in Item 18.
Optional	**18B**.	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter the appropriate diagnosis code without the decimal for any applicable secondary diagnosis.
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 furnished. When the name and address of the facility where the services were furnished is the same as the biller's name and address as submitted in Field 22, enter the word, "Same."

Completion	Item	Item Explanation and Instructions
Required	**21.**	**Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to participants, for the Department to consider payment of deductible and coinsurance amounts. Enter a capital “X” in the "Yes" box, if accepting assignment.
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.**	**HFS Provider Number** – Enter the 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 Physician – a practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Physician – 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
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to the Taxonomy for 837P table in Chapter 300.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29A.**	**TPL Code** – The patient's TPL code is to be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the three-digit TPL code. If the TPL code is not known, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Field 30. Do not report Medicare information in the TPL fields. **TPL Entries for Spenddown**. **TPL Entries for 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	Item Explanation and Instructions
		If the HFS 2432 shows a participant liability 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	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 provider 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 provider 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 Form HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider 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 have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter $0.00. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.
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 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 dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned invoices will be rejected. 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 HFS 3797 Medicare Crossover Invoice is a single page or two-part continuous feed 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 continuous feed form should be removed prior to submission to the Department. The yellow copy of the claim should be retained by the provider.

Invoices are to be mailed to the Department in the pre-addressed mailing envelopes, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department. Should envelopes be unavailable, the HFS 3797 (Medicare Crossover Invoice) can be mailed to:

Medicare Crossover Invoice
Illinois Department of Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Do not bend or fold claims prior to submission.

Forms Requisition: Billing forms may be requested on our website at the Medical Provider Forms Request page, or by submitting a HFS 1517 as explained in Chapter 100.

Appendix O-3

Preparation and Mailing Instructions for Form HFS 1409, Prior Approval Request

Form HFS 1409, Prior Approval Request, is to be submitted by the provider for the optometric services specified in Topic O-211 in order for the services to qualify for reimbursement.

Instructions for Completion

The form is available as a PDF-fillable form on the Department's website. It may also be printed from the website and legibly hand-written. Instructions for completion below follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

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

Required = Entry always required.

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

Not Required = Fields not applicable; leave blank.

Completion	Item	Item Explanation and Instructions
Required	**1.**	**Recipient #** – Enter the nine-digit number assigned to the patient for whom the service or item is requested.
Required	**2.**	**Recipient Name –** Enter the name of the patient for whom the service or item is requested.
Required	**3.**	**Birth date** – Enter the patient's birth date.
Required	**4.**	**Provider/NPI #** – Enter the provider number as shown on the Provider Information Sheet.

Completion	Item	Item Explanation and Instructions
Required	**5.**	**Provider Telephone #** – Enter the telephone number of the provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**6.**	**Provider Name** – Enter the name of the provider who will provide the service or item.
Required	**7.**	**Physician Name** – Enter the name of the optometrist or physician who signed the order or prescription recommending that the patient receive the specific item or service.
Required	**8.**	**Provider Street Address** – Enter the address of the provider.
Required	**9.**	**Physician Street Address** – Enter the address of the ordering practitioner.
Required	**10.**	**Provider City, State, ZIP Code** – Enter the address of the provider.
Required	**11.**	**Physician City, State, ZIP Code** – Enter the address of the ordering practitioner.
Conditionally Required	**12.**	**Diagnosis Code** - Enter the specific ICD-10 code without the decimal for the primary diagnosis described in Item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis** – Enter additional diagnosis codes, if applicable.
Conditionally Required	**14.**	**Diagnosis Description** – Enter the written description, which corresponds with the diagnosis code listed in Item 12.
Not Required	15.	Patient Height/Weight

Completion	Item	Item Explanation and Instructions
Required	**16.**	**Procedure Code** – Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested. For podiatry – if a quantity of two is requested (for instance, right and left), list the specific HCPCS code for the first, then 99199 for the second. **Description** – Briefly describe the services or items or materials to be provided. **Qty** – Enter the number of items to be dispensed in the time period covered by the prior approval request or enter the number of times the service is to be performed. **Cat. Serv** – Enter the two-digit category of service (COS) code corresponding to the related item/service. Valid entries are: 01 Physician Services 45 Optical Supplies **Prov Charge** – Enter the total amount to be charged for the item being requested. **Approved HFS Amt** – Leave Blank. **Begin Date** – If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval is granted, leave blank. **End Date** – Indicate the ending date of service, if applicable. **Pur/Rent** – Leave blank. **Mod** – Leave blank.
Conditionally Required	**17-20**	To be used for additional procedures. If more than five procedures are listed, another request must be made.
Required	**21.**	**Additional Medical Necessity** – To be used for other medical information.
Not Required	22.	Approving Authority Signature
Required	**23.**	**Provider Signature/Date** – To be signed in ink by the individual who is to provide the service.

Instructions for Submittal

Before mailing, carefully review the prior approval request for completeness and accuracy. The provider is to submit the form to the Department as indicated below. The provider may wish to retain a copy in the provider's records.

A signed HFS 1409 and any additional documentation may be mailed to:

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Office Box 19115
Springfield, IL 62794-9115

With the exception of prior approval forms for polycarbonate lenses, the signed HFS 1409 may also be faxed to 217-524-7120.

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be billed until the approval notification is received.

Forms Requisition: The HFS 1409 (pdf) is available in a PDF-fillable format on the Department's website.

Appendix O-3a
Special Prior Approval Instructions for Polycarbonate Lenses for Adults

The Illinois Department of Corrections' (DOC) eyeglasses laboratory at Dixon, Illinois, has the capability to manufacture polycarbonate lenses. The Department will authorize the DOC lab to complete polycarbonate lens orders, instead of authorizing payment to the provider to obtain these lenses from an outside source.

Prior approval is required for polycarbonate lenses for adults, age 21 and older. Providers who request prior approval for polycarbonate lenses for adults must follow the process outlined below. **Polycarbonate lenses for children through age 20 do not require prior approval.**

- The HFS 1409, Prior Approval Request must be completed. Instructions for completing this form can be found in Appendix O-2 of this handbook. HCPCS polycarbonate lens Code V2784 must be the requested procedure code, and the eyeglasses prescription should be listed in Box 21.

- The HFS 1443 Provider Invoice must be completed identifying the procedure code for the dispensing fee.

- The HFS 2803 Optical Prescription Order (OPO) must be completed **and the checkbox for polycarbonate lenses must be marked.**

All three forms must be submitted to the Department together.

If the prior approval request is approved, the OPO will be forwarded to DOC for manufacture of the order, and the claim will be processed. The provider and patient will receive a letter of approval.

If the prior approval request is denied, the provider and the patient will receive a denial letter. The provider will be responsible for explaining to the patient that the Department did not approve the polycarbonate material for the lenses. The claim and OPO will be processed, and the eyeglasses will be fabricated without the polycarbonate material.

The patient may choose to purchase polycarbonate lenses through the provider at the patient's expense. If the patient elects to purchase polycarbonate lenses, the provider will arrange for fabrication of those lenses through an optical lab, and the patient will reimburse the provider. Eyeglass frames may still be obtained through the Department, even if the patient elects to purchase the lenses from the provider.

Requests for polycarbonate lenses must be mailed to:

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Office Box 19115
Springfield, Illinois 62794-9115

Requests for polycarbonate lenses cannot be faxed.

Appendix O-4

Explanation of Information On Provider Information Sheet

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 must be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet appears in Appendix O-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 reflecting the manner in which the provider is enrolled with the Department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

Field	Explanation
Enrollment Specifics	**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 04 = Group Practice **Enrollment Status** is a one-digit code and corresponding narrative that 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 Disregard the term NOCOST if it appears in this item. 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. **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 = Intent to Terminate C = Citation D = Delinquent Child Support E = Provider Review F = Fraud Investigations G = Garnishment L = Student Loan Suspension R = Intent to Terminate/Recovery T = Tax Levy X = Suspensions If there is an exception indicator, it may affect the provider's activity with the Department. If this item is blank, the provider has no exception.

Field	Explanation
Enrollment Specifics	Immediately following the **Exception Indicator** are 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 or not the provider has agreed to the Terms and Conditions in IMPACT.
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.
S.S.#	This is the provider's Social Security or FEIN number.
Specialty and Categories of Service	**Specialty Code** is a three-digit code and corresponding narrative verifying that an optometrist has received TPA/DPA certification. An entry in this item is followed by the date that the Department was notified of the certification. **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: 001 = Physician Services 003 = Optometric Services 045 = Optical Materials Each entry is followed by the date that the provider was approved to render services for each category listed.

Field	Explanation
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. **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 Administrative Contractor, to cross-over 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.

Appendix O-4a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 06/05/16
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 06/05/16
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
046011111

PROVIDER NAME AND ADDRESS

PROVIDER GENDER:
COUNTY
TELEPHONE NUMBER

D.E.A. #:
RE-ENRL IND: N DATE: 11/15/86

PROVIDER TYPE: 012 – OPTOMETRIST
ORGANIZATION TYPE: 01 – INDIVIDUAL PRACTICE
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/15/99 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 046011111 ENDING 03/31/16
UPIN#:
LAST TRANSACTION ADD AS OF 04/21/14 S.S.#:000000000
CLIA#:

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

COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	BEG DATE	REASON
001	PHYSICIAN SERVICES	11/15/99	003	OPTOMETRIC SERVICES	11/15/99	
045	OPTICAL SUPPLIES	11/15/99				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ANTHONY GOODSIGHT	1421 MY STREET	ANYTOWN	IL	62000	331313131-62000-01		11/15/99

DBA: GOODSIGHT'S VISION CARE
MEDICARE/PIN: 999999 VENDOR ID: 01

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

********** PLEASE NOTE: *********

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

Appendix O-5

Internet Quick Reference Guide

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

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Centers for Medicare and Medicaid Services (CMS)
Child Support Enforcement
Claims Processing System Issues
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)
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Place of Service Codes
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
State Chronic Renal Disease Program