

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Required	4.	Type of Bill – A 4-digit field is required. Do not drop the leading zero in this field.
Optional	5.	Fed. Tax No.
Required	6.	Statement Covers Period
Optional	10.	Patient Birth Date – If the birth date is entered, the Department will, where possible, correct claims suspended due to participant name and number errors. If the birth date is not entered, the Department will not attempt corrections.
Required	12.	Admission Date
Required	17.	Patient Discharge Status
Conditionally Required <i>New Effective August 1, 2019</i>	31-34.	Occurrence Code and Date – For claims containing charges for the Service Intensity Add-on available for the last seven days of the patient’s life, enter Occurrence Code 55 and the patient’s date of death. If the SIA days span two calendar months, the occurrence code and date of death must be entered on the claim preceding the final claim and also entered on the claim for the month in which death occurred.
Conditionally Required	35-36.	Occurrence Span Code/From/Through – Indicate the non-covered date span.

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Required	39-41.	<p>Value Codes – Value Code 80 is required for all hospice claims (the number of days covered by the primary payer). The other value codes below are conditionally required based upon the particular claim:</p> <p>Value Code 81 – The number of days of care not covered by the primary payer.</p> <p>Value Code G8 – Providers must use Value Code G8 in the code field with the appropriate CBSA in the amount field on their claims to identify the location of the inpatient facility where inpatient respite (Revenue Code 0655) or general inpatient (Revenue Code 0656) care services were provided. The CBSA code is to be reported right justified to the left of the dollar/cents delimiter.</p> <p>Value Code 61 – Providers must use Value Code 61 in the code field with the appropriate CBSA in the amount field on their claims to identify the location where routine home care (Revenue Code 0651) or continuous home care (Revenue Code 0652) services were provided. The CBSA code is to be reported right justified to the left of the dollar/cents delimiter.</p> <p>Value Code 66 – Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The 2432, Split Billing Transmittal, must accompany the claim.</p>
Required	42.	<p>Revenue Code – Enter the appropriate hospice Revenue Code(s) for the service provided.</p> <p>055X – Service Intensity Add-on/Registered Nurse Service 056X – Service Intensity Add-on/Social Work Services 0651 – Routine Home Care 0652 – Continuous Home Care 0655 – Respite Care 0656 – General Inpatient Care 0657 – Physician Services 0658 – Nursing Home Room and Board</p> <p>The 23rd revenue line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.</p>

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Required	43.	Revenue Description
Required	44.	HCPCS/Accommodation Rates – For Revenue Codes 0651, 0652, 0655, 0656, and 0658, report the rate assigned to the revenue code. For Revenue Code 055X, report HCPCS code G0299. For Revenue Code 056X, report HCPCS code G0155. For Revenue Code 0657, report the HCPCS/CPT associated with the service.
Required <i>Revised Effective August 1, 2019</i>	45.	<p>Service Date A service line date is required on all hospice services. Prior to August 1, 2019, a service line date was already required for Revenue Codes 0652 – Continuous Home Care, 055X – Registered Nurse Service (SIA Add-on), and 056X – Social Work Services (SIA Add-on) to identify the service units billed each day.</p> <p>For Revenue Codes 0651 – Routine Home Care, 0655 – Inpatient Respite Care, 0656 – General Inpatient Care, 0657 – Physician Services and 0658 – Nursing Home Room and Board: Providers may combine the total number of days for one revenue code on one line showing the beginning service date in FL 45 and the total number of days in FL 46, as long as the service dates are consecutive.</p> <p>If the service dates are not consecutive, providers need to split the dates for that revenue code on separate service lines rather than combining the days on one line. This is especially important for the calculation of the RHC high/low payment rate.</p>
Required	46.	<p>Service Units</p> <ul style="list-style-type: none"> • Revenue Code 055X is reported in ¼ hour units • Revenue Code 056X is reported in ¼ hour units • Revenue Code 0651 is reported in calendar days • Revenue Code 0652 is reported in ¼ hour units • Revenue Code 0655 is reported in calendar days • Revenue Code 0656 is reported in calendar days • Revenue Code 0657 is reported as the number of physician visits associated with the HCPCS code billed • Revenue Code 0658 is reported in calendar days
Required	47.	Total Charges (By Revenue Code category) For revenue code 0001, see FL 42 above.
Conditionally Required	48.	Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.

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Required	50.	Payer – Illinois Medicaid or 98916 must be shown as the payer of last resort
Conditionally Required	51.	<p>Health Plan Identification Number</p> <p>Three-Digit TPL Code [space] Two-Digit Status Code (Required if there is a third party source)</p> <p>TPL Code – If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the TPL Code Directory on the Department's website.</p> <p>Status Code – 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.</p> <p>The TPL Status Codes are:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.</p> <p>08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.</p>