

## GENERAL APPENDIX 6

### ADJUSTMENTS

An adjustment form is used to adjust an incorrect payment, which has been reported on Form HFS 194-M-1, Remittance Advice.

Adjustment forms cannot be used to adjust:

- a rejected service
- a suspended claim
- a claim which is still being processed by the Department

To correct information on a claim which is suspended or still being processed, the provider must wait for the claim to appear with its final disposition on a Remittance Advice. Only then can the claim be adjusted

The Adjustment Form is a three-part carbon–interleaved form. When this form is initiated by the provider, the provider retains the last copy of the form and submits the original and first copy to the Department.

The Department is gradually replacing the three-part form with single sheet forms that are machine readable. When a supply of Adjustment Forms is requested, a provide may receive single sheet forms printed in red ink. When the provider initiates this form, the provider should retain a photocopy of the form and submit the original to the Department.

All adjustment Forms are to be mailed in the pre-addressed Adjustment Envelope (HFS 1416) supplied by the Department. To be considered for additional payment, Adjustment Forms must be received by the Department within 12 months of the voucher date on which the original payment was made.

If an adjustment is denied the provider will receive a copy of the form indicating the reason for the denial. When the adjustment action is finalized, the action will be reported ion a Remittance Advice (form HFS 194-M-1), under the heading “Adjustment”.

There are three versions of the Adjustment Forms, based on the type of service being adjusted. The differences between the forms are minor. The following pages contain facsimiles of the single sheet forms printed in red ink, for each of the three versions:

- HFS 1410 (Pharmacy Adjustment)
- [HFS 2249](#) (UB-04 Billers – Hospitals, Hospices, and Renal Dialysis Center), and
- HFS 2292 (NIPS Providers – Non-institutional Providers).

The instructions for completing the forms follow the facsimiles.

## Reduced Facsimiles of Form HFS 1410 (Single-sheet version)

<b>ADJUSTMENT (PHARMACY)</b>		1. DOCUMENT CONTROL NUMBER <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
2. PROVIDER NAME <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>	3. PROVIDER NUMBER <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>	4. PAYEE <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>	5. PROVIDER REFERENCE <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>
ADDRESS <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>			
CITY	STATE	ZIP	
<div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>			
<b>ADJUSTMENT TO</b>  6. VOUCHER NUMBER <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div> 7. DOCUMENT CONTROL NO. <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div> 8. SERV SECT 9. DATE OF SERVICE <div style="display: flex; justify-content: space-between;"><div style="border: 1px solid black; width: 20%; height: 20px; margin-top: 5px;"></div><div style="border: 1px solid black; width: 60%; height: 20px; margin-top: 5px;"></div></div> 10. NDC <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>	<b>RECIPIENT OF SERVICE</b>  11. RECIPIENT NAME (FIRST, MI, LAST) <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div> 12. RECIPIENT NUMBER <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div> 13. DATE OF BIRTH <div style="border: 1px solid black; width: 90%; height: 20px; margin-top: 5px;"></div>	<b>ADJUSTMENT DESCRIPTION</b> ADJ. 14. TYPE 15. NDC <div style="display: flex; justify-content: space-between;"><div style="border: 1px solid black; width: 20%; height: 20px; margin-top: 5px;"></div><div style="border: 1px solid black; width: 60%; height: 20px; margin-top: 5px;"></div></div> 16. QUANTITY 17. CHARGES <div style="display: flex; justify-content: space-between;"><div style="border: 1px solid black; width: 20%; height: 20px; margin-top: 5px;"></div><div style="border: 1px solid black; width: 60%; height: 20px; margin-top: 5px;"></div></div> 18. TPL 19. TPL AMOUNT <div style="display: flex; justify-content: space-between;"><div style="border: 1px solid black; width: 20%; height: 20px; margin-top: 5px;"></div><div style="border: 1px solid black; width: 60%; height: 20px; margin-top: 5px;"></div></div>	
<b>FOR PROVIDER USE ONLY</b> 20. REASON ADJUSTMENT REQUESTED  <p style="text-align: center;">This is to certify that the information above is true, accurate, and complete.</p> <p>Completion mandatory, Ill. Rev. Stat., Cha 23 P.A. code. Failure to complete may result in the Department taking unfavorable action. Form has been approved by the Forms Management Center</p>			
21. PROVIDER SIGNATURE		22. DATE	
<b>FOR ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICE USE ONLY</b>			
23. TYPE	24. CAT SERV.	25. CREDIT AMOUNT	27. CR%
28. RECOUPMENT BEGINS DATE OF SERVICE	30. OLDRATE	32. ERROR CODE	33. REASON CODE
26. DEBIT AMOUNT	29. RECOUPMENT BEGINS DATE VOUCHER DATE	31. NEW RATE	
34. REASON ADJUSTMENT MADE OR DENIED		35. EMPLOYEE	36. DATE
37. _____ AUTHORIZED HFS SIGNATURE			
HFS 1410 (R-7-99)		IL478-1114	

## Reduced Facsimiles of Form HFS 2249 (Single-sheet version)

<b>ADJUSTMENT (HOSPITAL)</b>		1. DOCUMENT CONTROL NUMBER	
AAH		<b>61</b>	
2. PROVIDER NAME	3. PROVIDER NUMBER	4. PAYEE	5. PROVIDER REFERENCE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ADDRESS			
<input type="text"/>			
CITY	STATE	ZIP	
<input type="text"/>			

<b>ADJUSTMENT TO</b> 6. VOUCHER NUMBER <input type="text"/> 7. DOCUMENT CONTROL NO. <input type="text"/> 8. SERV SECT 9. DATE OF SERVICE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 10. <input type="text"/>	<b>RECIPIENT OF SERVICE</b> 11. RECIPIENT NAME (FIRST, MI, LAST) <input type="text"/> <input type="text"/> <input type="text"/> 12. RECIPIENT NUMBER <input type="text"/> 13. DATE OF BIRTH <input type="text"/>	<b>ADJUSTMENT DESCRIPTION</b> ADJ. 14. TYPE 15. <input type="text"/> <input type="text"/> 16. 17. CHARGES <input type="text"/> <input type="text"/> 18. TPL 19. TPL AMOUNT <input type="text"/> <input type="text"/> <input type="text"/>
--	--	--

**FOR PROVIDER USE ONLY**  
 20. REASON ADJUSTMENT REQUESTED

**This is to certify that the information above is true, accurate, and complete.**

Completion mandatory, Ill. Rev. Stat., Cha 23 P.A. code. Failure to complete may result in the Department taking unfavorable action. Form has been approved by the Forms Management Center

21. PROVIDER SIGNATURE \_\_\_\_\_ 22. DATE \_\_\_\_\_

**FOR ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICE USE ONLY**

PROCESS	CAT	25. CREDIT AMOUNT	27. CR%	BEGIN DATE	30. OLDRATE	ERROR
23. TYPE	24. SERV.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	32. CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
26. DEBIT AMOUNT		29. THRU DATE		31. NEW RATE		
<input type="text"/>		<input type="text"/>		<input type="text"/>		
33. REASON ADJUSTMENT MADE OR DENIED				34. EMPLOYEE	35. DATE	
				<input type="text"/>	<input type="text"/>	
36. AUTHORIZED HFS SIGNATURE _____						

HFS 2249 (R-6-99) IL478-1067

## Reduced Facsimiles of Form HFS 2292 (Single-sheet version)

<b>ADJUSTMENT (NIPS)</b>		1. DOCUMENT CONTROL NUMBER	
2. PROVIDER NAME	3. PROVIDER NUMBER	AAA	4. PAYEE
5. PROVIDER REFERENCE			
ADDRESS			
CITY STATE ZIP			
<b>ADJUSTMENT TO</b>	<b>RECIPIENT OF SERVICE</b>	<b>ADJUSTMENT DESCRIPTION</b>	
6. VOUCHER NUMBER	11. RECIPIENT NAME (FIRST, MI, LAST)	14. ADJ. TYPE	15. ITEM OR SERVICE
7. DOCUMENT CONTROL NO.	12. RECIPIENT NUMBER	16. QUANTITY	17. CHARGES
8. SERV SECT 9. DATE OF SERVICE	13. DATE OF BIRTH	18. TPL	19. TPL AMOUNT
10. ITEM OR SERVICE			
<b>FOR PROVIDER USE ONLY</b>			
20. REASON ADJUSTMENT REQUESTED			
<b>This is to certify that the information above is true, accurate, and complete.</b>			
Completion mandatory, Ill. Rev. Stat., Cha 23 P.A. code. Failure to complete may result in the Department taking unfavorable action. Form has been approved by the Forms Management Center			
21. PROVIDER SIGNATURE			22. DATE
<b>FOR ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICE USE ONLY</b>			
PROCESS TYPE	CAT SERV.	25. CREDIT AMOUNT	27. CR%
28. RECOUPMENT BEGIN DATE	DATE OF SERVICE	30. OLDRATE	ERROR CODE
23. TYPE	24. SERV.	26. DEBIT AMOUNT	32. CODE
29. RECOUPMENT BEGIN DATE	VOUCHER DATE	31. NEW RATE	REASON CODE
34. REASON ADJUSTMENT MADE OR DENIED		35. EMPLOYEE	36. DATE
37. AUTHORIZED HFS SIGNATURE			
HFS 2292 (R-5-99)		IL478-1114	

**ADJUSTMENT PREPARATION AND MAILING INSTRUCTIONS**

- HFS 1410 (Pharmacy Adjustment),
- [HFS 2249](#) (Hospital Adjustment), and
- HFS 2292 (NIPS Adjustment)

The form should be either typewritten or legibly hand printed in ink. Any required item left blank may result in the adjustment form being returned to the provider for proper completion. The following explanation and instructions for completion correspond with the numbered entry fields on the adjustment forms:

1. **DOCUMET CONTROL NUMBER** – Leave blank. This field will be completed by the Department.
2. **PROVIDER NAME (and) ADDRESS** – Enter the provider’s name and address as it appears on the Provider Information Sheet.
3. **PROVIDER NUMBER** - Enter the provider’s number exactly as it appears on the Provider Information sheet. Do not use any spaces, hyphens, etc.
4. **PAYEE** - Enter the single digit number of the payee to which payment was made. Payees are coded numerically on the Provider Information Sheet
5. **PROVIDER REFERENCE** - Completion of this field is optional; however, the numerical and/or alphabetical characters (up to a maximum of 10) utilized in the provider’s accounting system for identification purposes may be entered. If an entry is made in this field, the information will be reported back to the provider on a future remittance advice reporting the disposition of the adjustment.
6. **VOUCHER NUMBER** - Enter the eight digit identifier, which appears in the lower left corner of the Remittance Advice, which reported payment of the service.
7. **DOCUMENT CONTROL NO.** - Enter the Document Control Number, which appears in the first column on the left of the Remittance Advice.
8. **SERV. SECT. (Service Section) (NIPS and Pharmacy only)** - Enter the appropriate number to identify the specific Service Section to be adjusted. This number appears on the Remittance Advice in the first column on the left below the participant’s name.
9. **DATE OF SERIVCE** – Enter the date of service in the MMDDYY format as it appears on the Remittance Advice for the particular service/item to be adjusted. For UB-04 billers, for claims for more than one day of service, enter the last paid date of service from the remittance advice. For NIPS adjustments a separate form is required for each date of service.
10. **ITEM OR SERIVCE (NIPS only), NDC (Pharmacy only)** – NIPS provider enter the procedure code, pharmacy providers enter the NDC for the item or the

service to be adjusted as it appears on the Remittance Advice. UB-04 billers leave blank.

11. RECIPIENT NAME – Enter the patient’s name exactly as it appears on the Remittance Advice (first and last name).
12. RECIPEINT NUMBER – Enter the nine digit recipient number as it appears on the Remittance Advice.
13. DATE OF BIRTH - Enter the patient’s date of birth in the MMDDYY format as it appears on the Remittance Advice.
14. ADJ. (Adjustment) TYPE – On all provider-initiated adjustments, one of the following codes must be entered to identify the reason the adjustment is being requested:
  1. Third Party Collection – This code is to be used when payment is received for a claim from another source after payment was made by the Department. Repayment must be made to the Department of any amount received from another source up to the amount received from the Department.
  2. Billing or payment error on an individual Service Section detected by the provider or, for UB-04 billers, when a claim has been paid in error. This code is to be used when the provider determines:

Payment was made based on erroneous information entered in a Service Section of the claim such as an incorrect procedure code or charge.

or

A Service Section was paid in error, e.g., a duplicate payment, a payment made on behalf of a patient unknown to the provider, etc.
  3. Reconsideration – This code is to be used if the provider wants to ask that the Department review and determine whether special circumstances may permit a change in the amount paid for a specific service. This adjustment type does not apply to UB-04 billers.
15. ITEM OR SERVICE (NIPS only), NDC (Pharmacy only) – This field is used only when the original claim contained an error in the entry of the procedure code number or NDC number by the provider, or when the Remittance Advice returned to the provider showed a procedure code number or NDC number different from that originally submitted. Enter the correct procedure code or NDC number, which should have appeared. UB-04 billers leave blank.
16. QUANTITY (NIPS and Pharmacy only) – For NIPS and pharmacy adjustments enter the correct quantity that should have been billed on the original claim. Not applicable to speech-language therapy service. UB-04 billers leave blank.

17. CHARGES - For Adjustment Type 01, enter the amount paid by the Department as shown on the Remittance Advice.

For Adjustment Type 02, when the reason for adjustment is a billing or payment error, enter the correct charge.

For Adjustment Type 03, enter the charges as it appears on the provider's copy of the claims

18. TPL (Third Party Liability) – For Adjustment Type 01, enter the appropriate code, as shown in General Appendix 9, to identify the type of third party from whom payment was received.
19. TPL AMOUNT – For Adjustment Type 01, enter the exact amount received from the third party payer. If the third party payment exceeds the Department's payment, enter the amount received from the Department. (Note that a line distinguishing cents has been pre-printed.)

When reporting an error in the original TPL amount, which appeared on the claim, enter the difference.

20. REASON ADJUSTMENT REQUESTED – The provider must enter a clear and concise explanation of the reason the adjustment is being requested.
21. PROVIDER SIGNATURE – After reading the certification, the provider or an authorized representative must sign the completed form. The individual must sign his or her own name. The signature must be handwritten black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned adjustment forms will not be accepted by the Department and will be returned to the provider.
22. DATE - The date should reflect the date the adjustment form is signed. This entry may be either handwritten or typed.

Before mailing the adjustment form, providers are encouraged to review it for completeness and accuracy.

## DEPARTMENT ACTION ON ADJUSTMENTS

When the Department receives an adjustment form initiated by a provider, a Document Control Number will be entered in box #1 of the form. This is a unique number to identify the particular adjustment in Department files. Department staff will complete boxes 23 through 37 on NIPS and pharmacy adjustments, or boxes 23 through 36 on hospital adjustments, as follows:

23. **PROCESS TYPE** - This field identifies how the Department has processed the adjustment. It is a two digit number followed by either C for Credit or D for Debit. A credit signifies a deduction from the provider's payment unless the reason for the credit is a returned check. A debit signifies an addition to the provider's payment. The various process types are described below:

### 01C (Credit) or 01D (Debit)

Credit – TPL – This process type is created when the provider reports either:

- 1) the omission of TPL payment date on the original claim, e.g. when TPL payment was unknown at the time of billing,
- or
- 2) when a third party payment or amount was incorrectly entered on the claim, e.g., \$10.00 instead of \$100.00.

When the Process Type is 01C, the credit amount will be automatically recovered from the future payments due the provider from the Department.

Debit – TPL- This process type is used when the provider incorrectly entered the third party payment amount on the claim, for example, as \$100.00 instead of \$10.00. The debit amount will be added to a future payment due the provider from the Department.

### 03C (Credit) or 03D (Debit)

This process type is used when the Department has approved the provider's request for reconsideration.

### 05C – Credit Only

This type reports the receipt and processing of the provider's check submitted in response to findings of an audit conducted by the Department.

### 06C – (Credit) Only

This type represents a recoupment. Such credits will be collected by the Department from future payments due the provider.



### 09C (Credit) or 09D (Debit)

**Credit** - This process type is created by the Department when a separate adjustment has been processed to void a claim. Type 09C is necessary only when the voided claim has contained a debit adjustment. Because the Department only processes debit adjustments to valid paid claims, debit adjustments must be recouped when the original service is voided. Type 09C adjustments will be collected from future payments due the provider.

**Debit** – This process type is used when an additional payment is due the provider for a variety of reasons. The Department will provide an explanation by sending a copy of the Adjustment Form to the provider.

### 11C (Credit) or 11D (Debit)

**Credit – Per Diem Credit – Mass to Detail** – When the Department is unable to decrease a provider's per diem or per visit rate prior to the effective date of a Department rate change; this adjustment is used for corrections. A date of service between the effective date of the rate change and the actual detail adjustment will be created for each service selected, when appropriate. Only the net Mass Amount of the adjustment is posted to the Payee Database.

**Debit – Per Diem Debit – Mass to Detail** – When the Department is unable to increase a provider's per diem or per visit rate prior to the effective date of a Department rate change; this adjustment is used for corrections. All dates of service between the effective date of the rate change and the actual date of the change will be automatically selected and adjusted. A detail adjustment will be created for each service selected, when appropriate.

### 12C (Credit) or 12D (Debit)

**Credit – Financial Recover Credit – Preliminary – Fiscal Year Reconciliation – Mass** – This adjustment is used to recover overpayments based on a preliminary audit of the fiscal year cost report. The amount of the overpayment will be recovered from future payments. This adjustment is used to reconcile payments to those provider paid on a per diem basis.

**Debit – Mass Debit – Preliminary – Fiscal Year Reconciliation – Mass** – This adjustment makes a lump sum payment to a provider based on a preliminary cost report audit. This adjustment is used to reconcile payments to those providers paid on a per dim basis.

### 13C – Credit Only

**Mass Credit – Preliminary – Fiscal year Reconciliation – Mass** – This adjustment is used to report the receipt of a provider's check, which serves as a year end reconciliation. This adjustment is used to reconcile payment to those providers paid on a per diem basis.

### 14C – Credit Only

This process type is used when the provider submits a check representing payment by a third party source.

### 15C (Credit) or 15D (Debit)

Credit – Financial Recovery Credit – Final –Maas – This adjustment is used to recover overpayments based on a final audit of the provider’s fiscal year cost report. It may also be used to re-post an adjustment type 21C or to recoup a purged date of service. The amount of the overpayment will be recovered from future payments. This adjustment is used to reconcile payments to those providers paid on a per diem basis.

Debit – Mass Debit –Final – Fiscal Year Reconciliation – Mass – This adjustment makes a lump sum payment to a provider based upon a final audit of the provider’s fiscal year cost report. This adjustment is used to reconcile payments to those providers paid on per diem basis.

### 16C – Credit Only

Mass Credit – Final – Fiscal Year Reconciliation – Mass – This adjustment is used to report a receipt of a provider’s check for overpayments based on a final audit of the provider’s fiscal year cost report. This adjustment is used to reconcile payment to those provider’s paid on a per diem basis.

### 17C (Credit) or 17D (Debit)

Credit – Third Party Liability Credit (Department Initiated) – This process type is initiated when a third party source payment is identified by the Department. The amount of the credit will be recovered from future payments to the provider.

Debit - Third Party Liability Debit (Department Initiated) – This process type is initiated when the Department determined a provider overstated the amount of TPL recovered on a service. The amount of the debit will be added to a future payment to the provider.

### 18C (Credit) or 18D (Debit)

Credit – Estimated Third Party Liability Credit – This adjustment is used when, after the Department has made payment for a service, the provider determines that a third party payment source is available. The provider bills the TPL source and requests the Department payment amount be decreased by the estimated amount of the third party payment. The amount of the credit will be recovered from the future payments to the provider.

Debit – In submitting a service for payment, the provider estimated the amount of the third party payment. Upon adjudication, the actual TPL amount

was less than the estimated TPL amount. The debit will be the difference between the estimated TPL amount and the actual TPL amount. The amount of the debit will be added to a future payment to the provider.

#### 19C – Credit Only

This process type is used when the provider submits a check to void Department records of an individual service. This process type can also be used to void a service that paid at zero.

#### 20C – Credit Only

This process type is used when the provider submits a check for a portion of the Department's payment on a single service.

#### 21C – Credit Only

This process type is used when the Department records of an individual service are to be voided and the amount is to be recovered from future payments to the provider.

#### 22C (Credit) or 22D (Debit)

This process type is used to adjust the amount of the Department's payment for a single service.

Credit – This process type signifies recoupment for future payments to a provider.

Debit – This process type signifies an additional payment for a single service.

#### 25C – Credit Only

This process type indicates the return by the provider of a debit the Department has issued.

#### 26C – Credit Only

This process type indicates the recoupment of a debit the Department has issued.

#### 32C – Credit Only

This process type indicates the receipt of a refund check from the provider for purged services, voided services or services which cannot be identified.

24. Category of Service – A two digit entry will appear identifying the category of service under which the original payment was issued.

25. Credit Amount – This is the total amount of credit due the Department as a result of the adjustment action. (It may be possible to deduct the total credit from one voucher or it may be necessary to make a deduction from more than one voucher.)

When a check has been submitted, the amount of each paid service will be entered here.

26. Debit Amount – This is the additional payment amount approved by the Department as a result of the adjustment action.
27. Credit Percent – Written as (000.00). This field is used when item 23 (Process Type) is 06C. This value represents the percent of each payment to the provider, which will be recovered and applied to the total amount of the credit.
28. Begin Date (UB-04 Billers), Recoupment Begin Date (Pharmacy and NIPS) – Beginning service date for which recoupment (06C) may be applied.
29. Thru Date (UB-04 Billers) – Ending voucher date for which a recoupment (06C) may be applied. Recoupment Begin Date (Pharmacy and NIPS) – Beginning voucher date for which recoupment (06C) may be applied.
30. Old Rate - Applicable to hospitals and hospices only.
31. New Rate – Applicable to hospitals and hospices only.
32. Error Code – for Department record keeping only
33. Reason Code (Pharmacy and NIPS only) – For Department record keeping only.
34. Reason Adjustment Made or Denied – This is a brief explanation of the Department's approval or denial of the adjustment. **Note:** This is item 33 on the Adjustment form for UB-04 billers.
35. Employee – A three digit number which designates either the Department employee or unit that completed the required data fields. **Note:** This is item 34 on the Adjustment form for UB-04 billers.
36. Date – The date on which the adjustment was reviewed. The format is MMDDYY. **Note:** This item 35 on the Adjustment form for UB-04 billers.
37. Authorized HFS Signature – The signature of the person completing the adjustment action. **Note:** This is item 36 on the Adjustment form for UB-04 Billers.

## GENERAL APPENDIX 7

### EXPLANATION OF REMITTANCE ADVICE INFORMATION FOR UB-04 BILLERS

The remittance advice reports the status of claims (invoices) and adjustments processed. Following is an explanation of the information that appears on the form and a completed example of Form HFS 194-M-1 Remittance Advice.

At the top of each page of the remittance advice, there are four labeled boxes:

**Provider Number** – This is the provider number exactly as it appears on the Provider Information Sheet.

**Type** - This is the HFS code, which identifies the type of provider for which the remittance advice is written. The possible codes are:

- 30 – General Hospital/Dialysis Centers
- 31 – Psychiatric Hospitals
- 32 – Rehabilitation Hospitals
- 39 – Hospice
- 46 – Ambulatory Surgical Treatment Centers
- 75 – Subacute Drug and Alcohol Treatment Facilities (OASA)

**Date** – This is the date the remittance advice was created.

**Page** - Each page will be sequentially numbered. When several locations are being paid to a central accounting address, page numbering will begin at one for each change of location (provider number).

The information included in the body of the completed remittance advice is organized according to the specific type of processing being reported. Two major categories of information may be printed in the center of the page preceding the report of action taken for Type 30, 31 and 32 as identified above. They are “Reconcilable” as shown in the example on page 6 and “Non-Reconcilable”. These categories are for Department use only.

One or more of four different types of action may be reported on the same remittance advice. Actions reported will be grouped on the report based on the type of action taken. The type of action will be printed in the center of the page preceding the report of action taken. Heading indicating the type of action appear in the following order:

**ADJUDICATED INVOICES – PREVIOUSLY SUSPENDED** – Claims listed in this group will have been reported on an earlier remittance advice as suspended (Status code SS). Adjudication of invoices reported under this heading has been completed and the final status code will appear for each invoice.

ADJUDICATED INVOICES (as shown in the example on page 6) – Claims listed in this group will report both invoices which are being paid and those being rejected and will include a report of action taken on the following types of invoices:

- Invoices which are being paid at the full amount billed.
- Invoices which are being paid at an amount less than the amount billed.
- Invoices for which no payment is being made. These will include:
  - Invoices containing errors.
  - Invoices showing credits' (Third Party payments) equal to or greater than the Department's established rate
  - Invoices showing "Spendedown" amount equal to or greater than the Department's established rate

SUSPENDED INVOICES – Claims in this group are being reviewed by the Department.

ADJUSTMENTS – This group reports any adjustments processed and claims which report late ancillary charges. Both approved and rejected late ancillary claims will appear in the adjustment section of the remittance advice. Provider-initiated adjustments, which cannot be processed as submitted and cannot be corrected by Department staff (by means of written correspondence or telephone contact with the provider) will be returned to the provider. These rejected adjustments will not appear on the remittance advice.

Within each of these groups, claims and adjustments will be reported in the Document Control Number sequence.

On the sample form which follows, data elements which appear in the unlabeled central areas of the form are identified by a circled number, for example, ①. This number corresponds with the item number in the following detailed explanation.

- ① Document Control Number – This is the unique number assigned by the Department to each invoice at the time it enters the payment processing system.
- ② Provider Reference – The reference number (up to 10 character) is shown if one was entered on the invoice by the provider.
- ③ Category of Service – The numeric code for the category of service will be printed in the third column of the remittance advice. All claims for the same category of service will be grouped together. The categories will appear in the sequence shown below although a remittance advice may not contain all categories of service.

- 20 – Inpatient Hospital Services (General)
- 21 – Inpatient Hospital Services (Psychiatric)
- 22 – Inpatient Hospital Services (Physical Rehabilitation)
- 23 – Inpatient Hospital Services (End Stage Renal Disease)
- 24 – Outpatient Hospital Services (General)

- 25 – Outpatient Hospital Services (End Stage Renal Disease)
- 26 – General Clinic Services
- 27 – Psychiatric Clinic Services (Type A)
- 28 – Psychiatric Clinic Services (Type B)
- 29 – Clinic Services (Physical Rehabilitation)
- 35 – Subacute Alcoholism and other Drug Abuse
- 37 – Skilled Care – Hospital Residing
- 38 – Exceptional Care – Hospital Residing
- 39 – DD/MI – Hospital Residing
- 60 – Hospice

- ④ Date of Service – For inpatient services, the date appearing in the first line is the first day included in that particular claim. The date appearing in the second line is the last day included in that particular claim. For outpatient or clinic services, the date appearing in the first line is the actual date of service.
- ⑤ Amount billed – This column reflects the amount of “Total Covered Charges” on the UB-04. NOTE: For Medicare crossovers, the amount shown will be the deductible and/or co-insurance.
- ⑥ Amount Allowed – This is a multi-purpose column which will show the amount of payment allowed by the Department. For late ancillary claims, the Amount Allowed field will be blank because no payment is being made.

When a check or warrant has been returned, this field will show the amount of the check or warrant.

For credit adjustments, the Amount Allowed field will show the actual amount being recovered on the particular voucher.

- ⑦ Status – One of the following code entries will appear explaining the action taken on the net charge made:

- PD – paid;
- RD – paid at a reduced rate to conform with Department standards
- RJ – rejected – no payment;
- SS – suspended – action pending.

For each adjustment or late ancillary claim, one of the following codes will appear:

- DB – debit
- CR – credit
- RT – checks returned by the provider
- PS – a processed credit adjustment for which no payable claims are available. When this occurs, the amount of the credit will be taken from a subsequent payment(s). The subsequent application of this credit will appear with the same Document Control Number and a status of CR.

- ⑧ **Error Code** – The remittance advice will report error codes to provide father information regarding the status of a claim or service. A three character code, one alpha character and two numeric characters, will appear to indicate the specific error, which caused the action taken by the Department. (See General Appendix 5 for error code details.)

When the “Status” entry is RJ, an error code will appear to identify the reason the claim was rejected. When the “Status” entry is SS, an error code will be shown to indicate the reason the claim was placed in suspense.

- ⑨ **Patient Name** – This identifies the patient to whom the billed services were provided.

**NOTE:** The words “Mass Adjustments” will appear rather than a patient’s name when an Adjustment Form HFS 2249 is processed to correct several claims or for an adjustment not related to specific claims, for example, to report a cost reconciliation.

- ⑩ **Recipient Number** – This indicates the unique nine-digit number entered on the claim for that patient.

- ⑪ **Item or Service** – Based on the category of service, this column will show one of the following entries:

- DAYS followed by the applicable number of days which appeared on the UB-04 invoice or the number computed by the Department based on the beginning and ending dates.
- PROCEDURE CODE/REVENUE CODE for outpatient services. This column will list the Ambulatory Procedure Listing (APL) code or the revenue code, which was used for pricing.
- LT ANC for billing of late services and/or room and board charges.
- ADJ followed by the Process Type code which appears in Item 23 of the adjustment form.

The Item or Service column is used to show any third party credit which appears on the invoice. The letters TPL will be followed by the three or four position code shown on the UB-04.

**SUMMARIES** – Following all the claim and adjustment entries, a summary of payments will appear for reconcilable and non-reconcilable payments. In most cases, this section of the report will be titled Provider Summary, as reflected in the example on page 6. In addition, summaries may appear which:

- Combine reconcilable and non-reconcilable claims reported for each category of service;
- Combine all categories of service for individual locations; and
- Combine all records on the remittance advice for all locations for the payee.



The final summary, which will include all reported claims and adjustments, is titled Provider Summary. There is a summary for each Category of Service and a Reconcilable Summary.

Adjustment amounts will not be included in the “Total Billed” amount. Credit and debit amounts will not be included in the “Payable Amount” but will be used in calculating the Remittance Total.

At the bottom of each page of a remittance advice, there are three labeled boxes as follows:

**Voucher Number** - This entry is the unique number assigned to the specific remittance advice. It consists of a four digit julian date followed by a four position sequence number. The voucher number must be identified on any correspondence to the Department about data on the remittance advice.

**Provider Mailing Address** - The address is the pay-to-address on the provider’s current Provider Information Sheet. The sixteen digit number above the payee name is a control number used by the Comptroller.

**Remittance Total** - When the remittance advice consists of multiple pages, this entry appears only on the final page. The amount entered is the amount of the State Warrant (check), which is reported on the remittance advice. The amount of the Remittance Total will be equal to the Payable Amount plus Total Debits minus Total Credits.

### Reduced Facsimile of Form HFS 194-M-1 for UB-04 Providers

PROVIDER NUMBER 480000000000	TYPE 30	ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES REMITTANCE ADVICE VENDOR COPY 1				DATE 05/02/02	PAGE 1	
DOCUMENT CONTROL NUMBER RECIPIENT NAME	PROV REFERENCE RECIPIENT NUMBER	CAT SERV	DATE OF SERVICE	NDC/ITEM OR SERVICE	AMOUNT BILLED	AMOUNT ALLOWED	STAT	ERROR CODES
① 210801543242  JANE IMAGINARY	② 7414  ⑨ ⑩ 111111111	③ 20	④ 040502  040602	⑪ DAYS 2	⑤ 1645.00	⑥ 963.90	⑦ PD	⑧ F01
PAYMENT REDUCED  PROVIDER SUMMARY  TOTALED BILLED 1645.00 TOTAL REJECTED 42.00 AMOUNT REDUCED 639.10 AMOUNT SPENDED  TOTAL TPL 0.00 TOTAL CREDITS TOTAL DEBITS  PAYABLE AMOUNT 963.90 RETURNED CHECK								
IF REMITTANCE TOTAL IS LESS THAN \$1.00, NO PAYMENT IS MADE								
VOUCHER NUMBER 21224123								
PLEASE REFER TO THIS 480 NUMBER AND TO THE DOCUMENT CONTROL NUMBER ON ALL CORRESPONDENCE  1 OF 1  HFS 194-M-2 (R-4-9)		PROVIDER MAILING ADDRESS  4800000000001111  ANONYMOUS HOSPITAL 9876 SCENICK AVENUE ANYTOWN, IL 66111				REMITTANCE TOTAL 963.90		

## GENERAL APPENDIX 8

### EXPLANATION OF REMITTANCE ADVICE INFORMATION FOR NON-INSTITUTIONAL PROVIDER (NIPS) AND PHARMACY BILLERS

The remittance advice reports the status of claims (invoices) and adjustments processed. Following is an explanation of the information that appears on the form and a completed example of form HFS 194-M-1, Remittance Advice.

At the top of each page of the remittance advice, there are four labeled boxes:

**Provider Number** – This is the provider number exactly as it appears on the Provider Information Sheet.

**Type** – This is the two digit HFS code, which identifies the type of provider for which the remittance advice is written.

**Date** – This is the date the remittance advice was created.

**Page** - Each page will be sequentially numbered.

One or more of four different types of actions may be reported on the same remittance advice. Actions reported will be grouped on the report based on the type of action taken. The type of action will be printed in the center of the page preceding the report of action taken. Headings indicating the type of action appear in the following order:

**ADJUDICATED INVOICES – PREVIOUSLY SUSPENDED** – Claims listed in this group will have been reported on an earlier remittance advice as suspended (Status Code SS). Adjudication of invoices reported under this heading has been completed and the final status code will appear for each Service Section.

**ADJUDICATED INVOICES** (as shown in the example on page 7) – Claims listed in this group will report both invoices which are being paid and those being rejected and will include a report of action take on the following types of invoices.

- Invoices on which all Service Sections are being paid.
- Invoices on which all Service Sections have been rejected.
- Invoices containing a mixture of paid, reduced, and/or rejected Service Sections.

**SUSPENDED INVOCIES** – Claims in this group are being reviewed by the Department. An entire invoice will be suspended when an error occurs in any Service Section.

**ADJUSTMENTS** – This group reports any adjustments processed. Provider-initiated adjustments which cannot be processed as submitted and which cannot be corrected by Department staff (by means of written correspondence or a telephone contact with the provider) will be returned to the provider. These rejected adjustments will not appear on the remittance advice.

Within each of these groups, claims and adjustments will be reported in Document Control Number sequence.

On the sample form, which follows, data elements, which appears in the unlabeled central areas of the form, are identified by a circled number, for example ⑤. This number corresponds with the item number in the following detailed explanation.

- ① Document Control Number – This is the unique number assigned by the Department to each invoice at the time it enters the payment processing system.
- ② Provider Reference – The reference number (up to 17 characters is shown if one was entered on the invoice by the provider.
- ③ Recipient Name – This identifies the patient to whom the billed services were provided.
- ④ Recipient Number – This indicates the unique nine-digit recipient number of the patient.
- ⑤ Service Section Number – This entry identifies the Service Section being reported from the claim. A deleted section will not appear.
- ⑥ Category of Service – This entry indicates the category of service for the service provided. The possible codes are:

- 01 – Physicians Service
- 02 – Dental Services
- 03 – Optometric Services
- 04 – Podiatric Services
- 05 – Chiropractic Services
- 10 – Nursing Services
- 11 – Physical Therapy
- 12 – Occupational Therapy
- 13 – Speech Therapy
- 14 – Audiology Services
- 17 – Anesthesia Services
- 18 – Midwife Services
- 30 – Healthy Kids
- 40 – Pharmacy
- 41 – Medical Equipment
- 43 – Clinical Laboratory Services
- 44 – Portable X-Ray Services
- 45 – Optical Supplies
- 48 – Medical Supplies

- 50 – Emergency Ambulance Transport
- 51 – Non-emergency Ambulance Transport
- 52 – MedicaR Transport
- 54 – Service Car
- 55 – Private auto
- 56 – Other Transportation
- 57 – Nurse Practitioner Services

- ⑦ Date of Service – This entry is the date of service for the procedure/item reflected in the particular Service Section.
- ⑧ Item or Service – This entry is the procedure code/item number as entered on the claim
- ⑨ Amount Billed – This entry is the provider charge from the claim.
- ⑩ Amount Allowed – This entry is the amount of payment allowed by the Department. If the provider entered a TPL amount on the invoice, that amount was deducted by the Department when computing the allowed amount.
- ⑪ Status – This entry explains the action taken on the Service Section, using one of the following codes:
  - PD – paid as billed
  - RD – paid at a reduced rate to conform with Department standards
  - RJ – rejected – no payment
  - SS – suspended – action pending
- ⑫ Error code – The remittance advice will report error codes to provide further information regarding the status of a claim or service. A three character code, on alpha character and two numeric characters, will appear to indicate the specific error, which caused the action taken by the Department. (See General Appendix 5 for error code details.)

When the “Status” entry is RJ, an error code will appear to identify the reason the claim was rejected. When the “Status” entry is SS, an error code will be shown to indicate the reason the claim was placed in suspense.

Whenever an error or correction is made which relates to the entire document, the error message and associated error code will appear on the same line as the DCN. Examples of this type of error would be F16, “Provider Number has been corrected” or D03, “Missing Provider Signature”. All other error messages appear directly below the Service Section to which they apply.

## THIRD PARTY LIABILITY (TPL)

This information will be reported when the participant has a TPL who may be responsible for paying a part or all of the charge for the item or service. This data will appear immediately below the Service Section Number. (See page 7 of this appendix for TPL information location.) Information appearing in this section is intended as an aid to the provider when billing the third party. TPL Informational Headers will be computer printed to correspond with the following items.

- No (Number) – This is the number corresponding to the entry for the various service lines. In a few situations, different third party resources may be applicable to separate Service Sections appearing on a single invoice. In these cases, the number should be used to determine which services are to be billed to each third party.
- Source – This entry identifies the coverage (first character) and company code (second through fourth positions). General Appendix 9 contains a list of coverage and company codes.
- Insuring Organization – If coverage is provided to the patient through employment or another group, the name of that organization will appear.
- Insurance Co. Name – The name corresponding to the TPL source will appear here.
- Billing Address – This is the address to which the third party billing should be sent.
- Policyholder – The policyholder may be the patient or someone else, e.g., a Parent or spouse.
- Group No/cert No – If the Department has a group number or policy certificate number for the coverage, it will be displayed beneath policyholder's name.

## ADJUSTMENTS

The final type of action, which may be reported on the remittance advice concerns adjustments. Refer to page 7 of this appendix for the location on the remittance advice where the adjustment information will be reported. The following information will be shown for each adjustment.

- Document Control Number – This is the unique number assigned by the Department to the specific Form HFS 2292. Adjustment (NIPS), at the time of processing.
- Provider Reference – The provider's reference number (up to 17 characters) is shown if one was entered on the invoice by the provider.
- Recipient Name – This entry identifies the participant for whom the adjustment is being processed. Please note that in the situation when the adjustment is for more than one unique service a "Processing Name" (i.e., Mass Adjustment) will be used.
- Recipient Number – This entry indicates the unique nine digit number of the participant.
- Date of Service – This is the date associated with the original paid service. In the situation when the adjustment is for more than one unique service a "Processing Date", not associated with any particular service, will be used.

- Process Type – The coding, which specifies how an adjustment was processed by the Department. (Process Types are listed in General Appendix 6, Adjustments).
- Amount Approved – The amount of money to be paid on a debit or to be reported for personal check or returned warrant.
- If the status code for the adjustment is PS (Posted), this field will contain the total amount of the credit to be recovered from future payments.
- If the status code for the adjustment is CR (Credited), this field contains the cumulative amount collected, including the amount recovered in this voucher, toward the credit amount due.
- Amount Processed – The amount of money to be paid on a debit, or to be reported for a personal check or returned warrant, or the amount recovered against payments made on the voucher.
- Status – This field explains the action taken on the particular adjustment:
  - DB – Debit paid as shown.
  - CR – Credit application made against payment on the voucher.
  - PS – Credit was posted against future payments. No application made on this voucher.
  - RT – A personal check or returned warrant was processed for the amount shown.

⑬ Summary – A summary of the invoices and adjustments reported on the remittance advice will be printed for the provider. The summary lines appear as follows:

- Total Billed – The total for all charges associated with services adjudicated (either paid or rejected) or suspended in this voucher.
- Total Rejected - The total amount of charges for all rejected services reported in this voucher.
- Amount Reduced - The total amount of reductions made from charges on paid services in this voucher.
- Amount Suspended – The total amount of charges associated with all services reported as suspended in this voucher.
- Total TPL – The total amount of third party payments reported on services paid in this voucher.
- Total Credits – The total of all credit applications made against payments in this voucher.
- Total Debits – The total of all debits processed in this voucher.
- Payable Amount – The sum of the Amount Allowed for each service paid in the voucher.
- Returned check – The sum of all adjustments which reports on either personal checks or returned warrants which were processed in this voucher.

When there is only one provider per voucher, only a PROVIDER SUMMARY will be printed. When there are multiple providers reported on a voucher, there will be a PROVIDER SUMMARY for each provider and a PAYEE SUMMARY at the end of the voucher to summarize the activity of all providers reported on the voucher.

At the bottom of each page of a remittance advice, there are three labeled boxes as follows:

**Voucher Number** – This entry is the unique number assigned to the specific remittance advice. It consists of a four digit julian date followed by a four position sequence number whose first character is either a numeric value or an alpha character. The Voucher number must be included on any correspondence to the Department about data on the remittance advice. The Voucher number will appear on each page of the remittance advice.

**Provider Mailing Address** – The address is the pay-to-address on the provider's current Provider Information Sheet. The sixteen digit number above the payee name is a control number used by the State of Illinois Comptroller. This entry will appear on each page of the same remittance advice.

**Remittance Total** - When the remittance advice consists of multiple pages, this entry appears only on the final page. The amount entered is the amount of the State warrant (check), which is reported on the remittance advice. The amount of the remittance Total will be equal to the Payable Amount plus Total Debits minus Total Credits.



### Reduced Facsimile of Form HFS 194-M-1 for NIPS Providers

PROVIDER NUMBER 0360000000	TYPE 10	ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES REMITTANCE ADVICE VENDOR COPY 1				DATE 05/02/02	PAGE 1	
DOCUMENT CONTROL NUMBER RECIPIENT NAME	PROV REFERENCE RECIPIENT NUMBER	CAT SERV	DATE OF SERVICE	NDC/ITEM OR SERVICE	AMOUNT BILLED	AMOUNT ALLOWED	STAT	ERROR CODES
ADJUSTED INVOICES								
①	②							
210701054321	776414							
③								
JANE IMAGINARY	111111111 ④	⑥ 01	⑦ 040502	⑧ 37205	⑨ 1603.00	⑩ 935.00	⑪ RD	⑫
SECTION 01 ⑤		F01 PAYMENT REDUCED			TPL INFORMATION			
21070154322	776414							
JANE IMAGINARY SECTION 02	1111111111	01	040502	54150	42.00		RJ	
		R16 SERVICES INVALID FOR RECIPEINT SEX			ADJUSTMENT INFORMATION			
		PROVIDER SUMMARY						
		TOTALLED BILLED			1645.00			
		TOTAL REJECTED			42.00			
		AMOUNT REDUCED			668.00			
		AMOUNT SPENDED						
		TOTAL TPL			0.00			
		TOTAL CREDITS						
		TOTAL DEBITS						
		PAYABLE AMOUNT			935.00			
		RETURNED CHECK						
IF REMITTANCE TOTAL IS LESS THAN \$1,000, NO PAYMENT IS MADE								

  

VOUCHER NUMBER 2122D123	PROVIDER MAILING ADDRESS 0360000000011111111 ANONYMOUS PHYSICIAN GROUP, INC. 9876 SCENIC AVENUE ANYTOWN, IL 6611	REMITTANCE TOTAL 935.00
----------------------------	--	-------------------------------

PLEASE REFER TO THIS NUMBER AND TO THE DOCUMENT CONTROL NUMBER ON ALL CORRESPONDENCE  
 1 OF 1  
 HFS 194-M-2 (R-4-91)