




All Providers Handbook Supplement

**Illinois Department of Healthcare and Family Services
November, 2018**

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Revision History

Date	Reason for Revisions
Policies and procedures as of November 5, 2018 Published: November 5, 2018	New document

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Section 1: Introductory Billing Section

Preamble

This provider handbook issued by the [Illinois Department of Healthcare and Family Services](#) is intended to provide general coverage supplemental information and billing guidelines for members who are Medicaid Fee-for-Service (FFS) eligible. Verifying a member's eligibility is crucial to ensure correct coverage of services and limitations. Providers should refer to the appropriate [HealthChoice Illinois Managed Care Organization](#) (MCO) manual if a member is assigned to an MCO.

Timely Filing Requirements

With the exception of those claims that are received by the Department and immediately returned to the provider as being unacceptable for processing, all claims received are assigned a unique Document Control Number (DCN) and are systematically processed. The DCN consists of the date the claim was received by the Department (displayed as a [Julian date](#)) plus an individual number to identify the specific claim.


A claim, when the Department is the primary payer, will be considered for payment only if it is received by the Department no later than 180 days from the date on which the services or items were provided. This time limit applies to both initial and resubmitted claims. Rebilled claims received more than 180 days from the date of service will not be paid. For hospital inpatient claims, the 180 days begins on the date of discharge.

Claims which are not submitted and received in compliance with the time limits for claim submittal will not be eligible for payment by the Department and the State shall have no liability for payment thereof. Refer to [89 Ill. Adm. Code 140.20](#) for additional information on time limits for filing a claim.


Exceptions to 180-Day Time Limit

Exceptions are only considered when the changes affect a provider's ability to submit claims for reimbursement. The 180 day time limit for claim submittal will not apply, or is modified, in the following situations:

- Claims received from a provider operated by a unit of local government with a population exceeding 3,000,000 when local government funds finance federal participation for claims payment – subject to a timely filing deadline of 12 months from date of service. The 12 month deadline extends to any exceptions that indicate a 180 day extension for all other providers. Timeliness for replacement claims or a void & rebill transaction is the same as that indicated below.
- Medicare crossovers (Medicare payable claims) – subject to a timely filing deadline of 2 years from the date of service. Claims may be submitted electronically or on the paper [Form HFS 3797](#) (non-institutional claims) or UB-04 (institutional claims).

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- Medicare denied claims – subject to a timely filing deadline of 2 years from the date of service. Submit a paper [Form HFS 2360](#), [Form HFS 1443](#), [Form HFS 2209](#), [Form HFS 2210](#), or [Form HFS 2211](#) with the Medicare EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach [Form HFS1624](#), Override Request form, stating the reason for the override. For institutional claims, submit a paper UB-04 with the EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach [Form HFS1624A](#), UB-04 Override Request form, stating the reason for the override. See Claim Procedures for Medicare Covered Services for more information.
- New provider enrollment, provider re-enrollment, addition of a new specialty/sub-specialty, or addition of an alternate payee – applies only to those claims that could not be billed until the enrollment, re-enrollment, addition of a new specialty/sub-specialty, or payee addition was complete. The 180 day period shall begin with the date the enrollment, re-enrollment, or update was recorded on the provider file. Attach [Form HFS 1624](#), Override Request (NIPS providers) or [Form HFS 1624A](#), UB-04 Override Request (institutional providers), stating the reason for the request to a paper claim form. Upon receipt of claims with an override request, HFS staff will verify that the claim(s) could not have been billed without the change to the provider file.
- Retroactive Participant eligibility – 180 days from the Department’s system update viewed on MEDI when verifying eligibility. Please ensure eligibility verification is for the date of service and not current date or date range. Attach [Form HFS 1624](#), Override Request Form (NIPS providers) or [Form HFS 1624A](#), UB-04 Override Request Form (institutional providers) stating the reason for the override to a paper claim form.
- Long Term Care Admission eligibility - 180 days from the admission process date provided on HFS 2449A for eligible participants.
- Rebill of previously voided claim (Hospital and LTC claims) - Following completion of the void, a new original claim must be submitted within 90 days of the void DCN.
- Replacement or Void/Rebill of an entire claim or single service line (NIPS claims) – The Department will accept electronic transactions submitted through [MEDI](#) or via 837P to void or replace a paid claim (includes claims paid at \$0), or a claim that is pending to pay, if submitted within 12 months from the original paid voucher date.
 - The functionality of allowing replacement claims and claims to be re-billed following a void is for the purpose of correcting errors on previously submitted and paid claims (e.g. incorrect provider number, incorrect date of service, incorrect procedure code, etc.) and not for the purpose of billing additional services. A void of a claim may be processed electronically through the MEDI system or on a paper [Form HFS 2292](#).

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- Replacement/Void & Re-bill (NIPS claims) – To replace a single service line or entire claim in the MEDI system, enter Claim Frequency “7” (Replacement of Prior Claim). Detailed instructions on how to replace a claim electronically can be found in the [837P Companion Guide](#). This method is preferred as it requires no manual override.
- Void (NIPS claims) – To void a single service line or entire claim in the MEDI system, enter Claim Frequency “8” (Void/Cancel of Prior Claim). Detailed instructions on how to void a claim electronically can be found in the [837P Companion Guide](#).
- Please refer to step #1 below for a manual void and step #2 for resubmission:
 1. If not enrolled in the MEDI system, to manually void a single service line or an entire claim, a void may be completed by submitting a NIPS Adjustment [Form HFS 2292](#).
 2. Following completion of the void, a new original claim must be submitted within 90 days of the void DCN and may require manual override. If a manual override is required, attach [Form HFS 1624](#), Override Request Form, stating the reason for override to a paper claim. Community Mental Health Providers (provider type 036) who do not have a paper billing option should contact a billing consultant for override instructions.

NOTE: For void or replacement claims, the following data elements must match the original claim:

- Document Control Number - The 17-digit DCN from the original paid claim is required. Using the 12-digit DCN from the paper remit
 - Add ‘201’ to the beginning of that 12-digit DCN
 - Add either the 2-digit section number to void or replace a single service line, or ‘00’ to void or replace an entire claim, to the end of the 15-digit number
- Provider NPI or for atypical providers, the HFS Provider Number
- Recipient Identification Number
- [TPL](#) – Claims must be submitted to the Department within 180 days after the final adjudication by the primary payer. Claims submitted electronically must have TPL fields completed. Timely submission will be calculated systematically based on the TPL adjudication date. For this reason, no override request is necessary.
- In the case of long term care facilities, once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.
- Split bill – Claims must be submitted to the [Department](#) within 180 days from the date on the Form HFS 2432 (Split Billing Transmittal/Spendedown Form). Attach

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the Form HFS 2432 with [Form HFS 1624](#), Override Request (NIPS) or [Form HFS 1624A](#), UB-04 Override Request (institutional providers), stating the reason for the override to a paper claim form. TPL fields must be completed.

- Primary TPL Recoupment – Claims must be submitted within 180 days from the date of the recoupment notification letter. Attach a copy of the recoupment notification letter and [Form HFS 1624](#), Override Request (NIPS) or [Form HFS 1624A](#), UB-04 Override Request (institutional providers), stating the reason for the override to a paper claim form. TPL fields on the paper claim must be completed when applicable.
- Local Education Agencies (LEAs) – Claims must be submitted to the Department within 18 months from date of service. Claims may be submitted electronically or on the paper [Form HFS 1443](#).
- Errors attributable to the Department or any of its claims processing intermediaries that results in an inability to receive, process or adjudicate a claim – the 180-day period shall not begin until the provider has been notified of the error by either the date on the paper voucher/remittance advice or the fix date on the [Claims Processing System Issues webpage](#). For override information refer to the rebilling instructions posted on the webpage, or contact a billing consultant at 877-782-5565 in the absence of notification on the webpage.

Resubmitting Claims

Providers should resubmit claims only if their claims fail to appear in the [MEDI System](#) thirty (30) days after submission to the Department.


The provider should prepare a new original claim for submittal to the Department. It is the responsibility of the provider to ensure that a claim is submitted timely.

Exception:

[LTC](#) providers must direct bill the Department for their services in a manner similar to that utilized for Medicare services. This process is detailed in the [Long Term Care Direct Billing Resources](#).

Electronic Claim Submittal

All electronically submitted claims are subject to the same edits and are reported on a paper Form HFS 194-M-1 remittance advice and the electronic 835 in the same manner as paper claims. The same requirements for electronic claim submission, including verifying patient eligibility, billing known insurance carriers, and reporting [TPL](#) payments, exist as for paper claims. Claims that require an attachment cannot be submitted electronically and must be submitted to the Department on paper billing forms.

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Each remittance advice that reports electronically submitted claims will be accompanied by the Form HFS 194-M-C, Billing Certification. The provider who rendered the services and submitted the electronic claim for payment must review the remittance advice and attest to the accuracy of the information thereon by signing the billing certification.

The same signature requirements that apply to the signing of paper claims also apply to form HFS 194-M-C, Billing Certification. The signed form must be maintained in the provider's records for three years from the date of the remittance advice to which it relates or for the time period required by applicable federal and state law, whichever is longer.

Electronic submission of claims may be suspended during a period of time when the Department is performing an audit of the provider. If this occurs, the Department will notify the provider that paper claims must be submitted until notification is given by the Department to resume electronic billing.

Electronic Claims Capture (ECC)


Providers may submit all non-institutional claims, other than pharmacy claims, as well as institutional claims billed on form UB-04, electronically through the [Medical Electronic Data Interchange \(MEDI\)](#) Internet site or a [REV Vendor/Electronic Data Interchange Service \(EDI\)](#) trading partner. The Department accepts non-institutional claims in the X12 837 Professional standard, Version 5010A and institutional claims in the X12 837 Institutional standard, Version 5010A. Pharmacies must bill electronically through the [Pharmacy Benefits Management System, Medical Electronic Data Interchange \(MEDI\)](#) authorization system

The [MEDI Authorization System](#) provides a repository for authorization information for access to HFS' Internet applications. Because of federal internet standards, as well as HIPAA regulations, HFS requires authorization for some applications provided through the internet. In order to gain access to these applications, a person must register in the MEDI system. The [MEDI Getting Started](#) page presents what is required to use these applications.

The [MEDI system](#) is designed to be available 24-hours a day, 7 days a week with the exception for maintenance every day between 3:00 a.m. and 3:30 a.m. The Payee Registration function is only available from 8:00 a.m. to 5:00 p.m. CST, Monday through Friday.

Access to the [Medical Electronic Data Interchange \(MEDI\)](#) system is provided after successfully obtaining a 'digital certificate' from the Illinois Department of Central Management Services (CMS).

To meet the requirements of HIPAA, the Department provides the Internet Electronic Claims (IEC) System to handle the electronic transfer of HIPAA-compliant formats. The main purpose of the IEC System is to provide registered MEDI users the ability to perform basic processing functions.

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Users of the [MEDI system](#) will have access to certain IEC functions depending on the authorization they are granted by their employer's MEDI administrator(s). Following is a list of functions that are available:

- Eligibility Inquiry: allows providers to check a patient's eligibility.
- Claim Status: allows providers to check on the status of a claim. This function is available Monday through Friday from 8:00 a.m. to 5 p.m. CST. Single claim status is available for up to 90 days from bill date, while batch status is available for up to one year from bill date.
- Upload File(s): allows an authorized user to upload one or more transactions and more than one transaction type.
- Download File(s): allows an authorized user to download one or more transaction and more than one transaction type.
- Remittance Advice (835): allows the user to view and download Electronic Remittance Advices (ERAs).
- Direct Data Entry: allows real-time entry and submission of claims.

Recipient Eligibility Verification (REV)


The [Recipient Eligibility Verification \(REV\)](#) system is an interactive electronic system which allows providers to verify a participant's eligibility; submit claims electronically; check the status of claims in processing; and download batches of claim information.

Providers access the [REV](#) system through vendors (independent contractors) who have agreements with the Department to provide this service. REV vendors provide this service by various methods, including: standardized software for use on existing PCs; point-of-service devices; and custom programming of a provider's existing computer system to accept and transmit the Department's data.

All current [REV](#) vendors also act as clearinghouses for other public and private payers. In this role, REV vendors offer services beyond those related to the Department's programs. For example, these vendors may offer general computer accounting support, preliminary claim editing, accounts receivable posting, and claims submittal to various third party payers. Providers pay the REV vendors for whatever mix and volume of services are selected. Providers are encouraged to contact all vendors on the list to determine which vendor will best meet the provider's needs. Providers should consider whether the provider's computer will be able to access a vendor's system. Additionally, providers should check the vendor's charges for use of the system and determine whether there are services other than those listed above which the REV vendor offers.

Electronic Data Interchange (EDI) Service Trading Partners

[Electronic Data Interchange \(EDI\) Service](#) (EDI) will eventually replace the Recipient Eligibility Verification System. Many of the same services offered through REV will be available through the Department approved EDI trading partners. Providers will be notified when this change occurs.

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Ordering of Claim Forms and Envelopes

Forms and envelopes should be requested on the Department's [website](#). If the form needed is not listed as a selection on the on-line forms request, provide the form number and quantity on the fields at the bottom of the online form.

Form requests submitted by mail must be submitted using [Form HFS 1517-Provider Forms Request](#), and mailed to the preprinted address on the top of the form. Providers should submit requests for forms or envelopes at least three weeks in advance of needing the material. The Department will not mail forms in response to telephone requests.

In order to receive a supply of forms, a billing service must supply (in addition to the name of the company and its mailing address) the name and provider ID of at least one HFS enrolled provider. UB-04 claim forms are not provided by the Department. Providers must purchase these forms from private vendors.

Paper Claim Submittal

Additional instructions for paper claim preparation and submittal for specific services or provider types are included in Section 5 of this Supplement.


Claims Preparation

Claims must be legibly signed and dated in black ink by the provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable. An authorized representative must be an employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. Such a representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service.

It is mandatory that claims are submitted to the Department only on original billing forms if supplied by the Department. Photocopies or other facsimile copies cannot be accepted for payment purposes.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. The Department offers a claim scanability/imaging evaluation. Turnaround on a claim scanability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Send sample claims with a request for evaluation to the following address:

[Illinois Department of Healthcare and Family Services](#)
201 South Grand Avenue East
Second Floor—Data Preparation Unit
Springfield, Illinois 62763-0001

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Attention: Provider/Image System Liaison

HFS does not utilize the CMS 1500, Health Insurance Claim Form. Claims submitted on a CMS 1500 will not be processed or returned by the Department.

Mailing of Claims

All paper claims with the exception of the UB-04 are to be mailed in the pre-addressed envelopes supplied by the Department. Deviation from this requirement may delay processing. All other correspondence is to be mailed separately from claims, unless specified as a required attachment to a claim and addressed to the appropriate office as directed in the [handbook](#) for the specific provider or service type being billed. If the Department requests additional information in order to process a claim, the additional information should not be mailed to the Department without a claim attached.

To expedite processing of claims, the following procedures should be followed:


- Review all forms for accuracy and completeness.
- Do not fold or damage claims.
- Do not staple, paper clip, or otherwise attach claims together.
- Do not use liquid correction fluid or correction tape on claims.
- Mail as many claims as possible in one envelope.
- Place claims in envelope with all pages facing in the same direction. Keep each claim type separate.
- Do not mail claims that require special handling in the same envelope with routine claims.

UB-04 and HFS Forms Mailing Instructions and Addresses

The provider is to submit an original UB-04 form to the Department. The pin-feed guide strip should be detached from the sides of continuous feed forms. A copy of the claim is to be retained by the provider. Claims should be sent to the applicable post office box as follows:

Claim Form	Mail To Address
UB-04 Claims Without Attachments	Illinois Department of Healthcare and Family Services UB-04 Inpatient/Outpatient Invoices P.O. Box 19132 Springfield, Illinois 62794-9132
UB-04 Claims With Attachments	Illinois Department of Healthcare and Family Services UB-04 Inpatient/Outpatient Invoices With Attachments P.O. Box 19133 Springfield, Illinois 62794-9133
UB-04 Claims Requiring Special Handling by the Billing Consultants	Illinois Department of Healthcare and Family Services P.O. Box 19128 Springfield, Illinois 62794-9128
Adjustments Form HFS 2249 Institutional or Form HFS 2292 NIPS	Illinois Department of Healthcare and Family Services P.O. Box 19101

Claim Form	Mail To Address
	Springfield, Illinois 62794-9101
HFS 1409 Prior Approval Request	Illinois Department of Healthcare and Family Services Post Office Box 19124 Springfield, Illinois 62794-9124 Fax: 217-524-0099
HFS 1443 Provider Invoice For claims without attachments	Illinois Department of Healthcare and Family Services P.O. Box 19105 Springfield, Illinois 62794-9105
HFS 1443 Provider Invoice For claims with attachments	Illinois Department of Healthcare and Family Services P.O. Box 19118 Springfield, IL 62794-9118
HFS 2209 Transportation Invoice	Illinois Department of Healthcare and Family Services P.O. Box 19126 Springfield, Illinois 62794-9126
HFS 2210 Medical Equipment/Supplies Invoice For claims without attachments	Illinois Department of Healthcare and Family Services P.O. Box 19126 Springfield, Illinois 62794-9105
HFS 2210 Medical Equipment/Supplies Invoice For claims with attachments	Illinois Department of Healthcare and Family Services P.O. Box 19118 Springfield, Illinois 62794-9118
HFS 2211 Laboratory/Portable X-Ray Invoice For claims without attachments	Illinois Department of Healthcare and Family Services P.O. Box 19125 Springfield, Illinois 62794-9105
HFS 2211 Laboratory/Portable X-Ray Invoice For claims with attachments	Illinois Department of Healthcare and Family Services P.O. Box 19118 Springfield, Illinois 62794-9118
HFS 2212 Health Agency Invoice For claims without attachments	Illinois Department of Healthcare and Family Services P.O. Box 19125 Springfield, Illinois 62794-9125
HFS 2212 Health Agency Invoice For claims with attachments	Illinois Department of Healthcare and Family Services P.O. Box 19118 Springfield, Illinois 62794-9118
HFS 2360 Health Insurance Claim Form For claims without attachments	Illinois Department of Healthcare and Family Services P.O. Box 19105 Springfield, Illinois 62794-9105
HFS 2360 Health Insurance Claim Form For claims with attachments	Illinois Department of Healthcare and Family Services P.O. Box 19118 Springfield, Illinois 62794-9118
HFS 3701T Therapy Prior Approval Request	Illinois Department of Healthcare and Family Services Post Office Box 19124 Springfield, Illinois 62794-9105 Fax: 217-524-0099
HFS 3797 Medicare Crossover Invoice For claims without attachments	Illinois Department of Healthcare and Family Services Post Office Box 19109 Springfield, Illinois 62794-9109
HFS 3797 Medicare Crossover Invoice For claims with attachments	Illinois Department of Healthcare and Family Services Post Office Box 19115 Springfield, Illinois 62794-9115

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Forms Requisition

The Department does not supply the UB billing form. The [HFS 2249 Adjustment form](#) is available in an electronic PDF-fillable format on the Department's [Medical Programs Forms page](#). The Department does supply a pre-addressed mailing envelope, the Form HFS 1416 envelope, which providers may use to submit their adjustment forms. These envelopes may be ordered from the [Forms Request](#) page.

Claim Procedures for Medicare Covered Services

Charges for deductible and coinsurance amounts due for Medicare Part B covered services are to be submitted to the Department only after adjudication by the Medicare Administrative Contractor (MAC), or Medicare Advantage Plan (MAP).

Services billed to the MAC or Durable Medical Equipment (DME) MAC as primary claims will be "crossed over" to the Department electronically for payment consideration of coinsurance or deductibles or both. Claims from MAPs are not automatically crossed over. Claims should **not** be submitted directly to the Department when the Medicare Remittance Notice displays a message or code stating that the claim has been forwarded to the [Illinois Department of Healthcare and Family Services](#). A service that has been rejected for payment by Medicare may be submitted to the Department for payment consideration only when the reason for nonpayment is either that the:

- Patient was not eligible for Medicare benefits, or
- Service is not covered as a Medicare benefit, although is covered under the participant's Medicaid eligibility.


In such instances, the Department is to be billed only after final adjudication of the claim by the MAC or MAP.

Charges for deductible and coinsurance amounts due for Medicare Part A covered services are not automatically crossed over to the Department for adjudication. Providers are responsible for submittal of those claims to the Department after adjudication by Medicare.

Claims for participants enrolled in the Medicare-Medicaid Alignment Initiative (MMAI) should be submitted to the appropriate MMAI plan. Enrollment in the MMAI can be verified on [MEDI](#) or [REV/EDI](#) when making an eligibility inquiry under the "Managed Care Organization" section.

Claim Procedures for Recipient Restriction Program (RRP) Services

Claims for services to participants who have been restricted under the RRP to one or more primary provider types require no special forms or procedures as long as the services are provided by the designated primary provider type(s). For payment consideration, claims for restricted medical services rendered by a provider other than the participant's designated primary provider type(s) must be authorized by the participant's designated primary provider

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type(s). Authorization is documented on a [Form HFS 1662](#). The Form HFS 1662 is used by the designated primary provider type to refer an RRP participant to another provider for necessary services which the designated primary provider type cannot provide.

A completed [Form HFS 1662](#) must be attached to all non-pharmacy paper claims for restricted services rendered by a provider other than the participant's designated primary provider type. Form HFS 1662 may authorize one service date only. Therefore, the date of service on a claim must be for the date specified on Form HFS 1662. Multiple services billed on a single claim form may be attached to a single Form HFS 1662 provided that all dates of service are the same. The [Form HFS 1662](#) and the appropriate billing form must be mailed to: Illinois Department of Healthcare and Family Services, Post Office Box 19118, Springfield, IL 62794-9118.

These claims should not be resubmitted to the address listed above until a completed [Form HFS 1662](#) authorizing the service(s) and date of service is obtained from the participant's designated primary provider type(s).

Claims submitted by a pharmacy for a participant receiving prescriptions from a prescriber (other than the physician or physician employed by the clinic that the participant is restricted to) should be submitted electronically whenever possible. If a paper claim (Form HFS 215CF – Drug Invoice) is prepared, then the [Form HFS 1662](#) must be attached when submitted. See [Handbook for Providers of Pharmacy Services](#) for detailed pharmacy billing instructions for electronic claim submissions for participants who are restricted under the RRP.

Remittance Advice Information


The remittance advice reports the status of claims (invoices) and adjustments processed. [The link provided here](#) contains an explanation of the information that appears on the form and a completed example of [Form HFS 194-M-2 Remittance Advice](#).

Adjustments

An adjustment form is used to adjust an incorrect payment, which has been reported on [Form HFS 194-M-2, Remittance Advice](#). Adjustment forms cannot be used to adjust a:

- rejected service
- suspended claim
- claim still being processed by the Department

To correct information on a claim which is suspended in a hold status, the provider must wait for the claim to appear in pending or adjudicated status, at which time the claim information may be corrected. NIPS providers may adjust a claim via an 837P void/rebill or replacement claim function. Please note, the replacement claim function is not available for institutional providers through the 837I format at this time.

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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 on a [Form HFS 194-M-2, Remittance Advice](#), under the heading "Adjustment".

There are three versions of paper adjustment forms, based on the type of service being adjusted. The three versions are:

- Form HFS 1410 - Pharmacy
- [Form HFS 2249](#) - Hospitals, UB-billers (hospices, renal dialysis centers and LTC facilities)
- [Form HFS 2292](#) - NIPS Providers (non-institutional providers)

Forms [HFS 2249](#) and [HFS 2292](#) can be completed on-line and printed for mailing to the Department.

LTC facilities must submit a [Form HFS 2249 Adjustment \(Hospital\)](#) to the Department to void a previously adjudicated claim for LTC services. Detailed information on the void and rebill process for LTC facilities, including an example of a completed [Form HFS 2249](#), can be found on the [Long Term Care Direct Billing Resources](#) webpage.

Mailing Instructions

Before mailing adjustment forms, providers are encouraged to review all forms for completeness and accuracy. The Department supplies preaddressed envelopes (HFS 1416 Adjustments) upon request. Providers may use the on-line [Medical Forms Request](#) to order a supply of the Form HFS 1416 adjustment form envelopes. Completed adjustment forms should be mailed to:


[Illinois Department of Healthcare and Family Services](#)
P.O. Box 19101
Springfield, IL 62794-9101

Adjustment Form Preparation

All adjustment forms should be either typewritten or legibly hand printed in black. 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 [Form HFS 2249](#) and [Form HFS 2292](#):

1. Document Control Number - Leave blank. This field is completed by the Department.
2. Provider Name (and) Provider Address - Enter the provider's name and address as it appears on the Provider Information Sheet.

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3. Provider Number (NIPS and Pharmacy) - Enter the provider's ID number (do not use the NPI) exactly as it appears on the Provider Information sheet. Do not use any spaces, hyphens, etc.

PAYEE (Hospital/UB billers) - Enter the single digit number of the payee to which payment was made. Payees are coded numerically on the Provider Information Sheet.

4. Payee (NIPS, Pharmacy) - Enter the single digit number of the payee to which payment was made. Payees are coded numerically on the Provider Information Sheet.

Provider Number (Hospital/UB billers and LTC facilities) - Enter the provider's number exactly as it appears on the Provider Information sheet. Do not use any spaces, hyphens, etc.

5. Provider Reference (NIPS and Pharmacy) - 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.

Provider NPI Number (Hospital/UB billers) - Enter the provider's National Provider Identifier.

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. (NIPS, Hospital/UB billers, Pharmacy and LTC facilities) - Enter the Document Control Number, which appears in the first column on the left of the remittance advice.

8. Serv. Sect. (NIPS and Pharmacy) - 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.

COS (Hospital/UB billers) - Enter the appropriate Category of Service.

9. Date Of Service - 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 hospital/UB billers, when adjusting claims for more than one date of service, enter the first paid date of service from the remittance advice. For NIPS adjustments, a separate form is required for each date of service. For LTC facilities enter the claim begin date.

10. Item or Service (NIPS) - Enter the procedure code as it appears on the remittance advice.

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NDC (Pharmacy) - Enter the NDC for the item or the service to be adjusted as it appears on the remittance advice.

Provider Reference Number (Hospital/UB billers) - 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.

11. Recipient Name (NIPS, Hospital/UB billers, Pharmacy and LTC facilities) - Enter the patient's name exactly as it appears on the remittance advice (first and last name).
12. Recipient Number (NIPS, Hospital/UB billers, Pharmacy and LTC facilities) - Enter the nine digit recipient number as it appears on the remittance advice.
13. Date of Birth (NIPS, Hospital/UB billers, Pharmacy) - Enter the patient's date of birth in the MMDDYY format as it appears on the remittance advice.
14. ADJ. Type or Reason Adjustment Requested - On all provider-initiated adjustments, one of the following codes must be entered to identify the reason the adjustment is being requested:
 - 01 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.
 - 02 Billing or payment error on an individual Service Section detected by the provider; or for hospitals/UB 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.
 - 03 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/reason adjustment requested code does not apply to hospitals/UB billers.
15. Item or Service (NIPS) - This field is used only when the original claim contained an error in the entry of the procedure code number by the provider, or when the remittance advice returned to the provider showed a procedure code number different

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from that originally submitted. Enter the procedure code which should have been reported.

[NDC](#) (Pharmacy) - Used only when the original claim contained an error in the entry of the [NDC](#) number by the provider, or when the remittance advice returned to the provider showed a NDC number different from that originally submitted. Enter the NDC number which should have been reported.

Provider Signature (Hospital/UB billers and LTC facilities) - 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.

16. Quantity (NIPS and Pharmacy) - Enter the correct quantity that should have been billed on the original claim.

Date (Hospital/UB billers and LTC facilities) - The date should reflect the date the adjustment form is signed. This entry may be either handwritten or typed.

Department Action on Adjustments

When the Department receives an adjustment form initiated by a provider, a Document Control Number will be assigned to the adjustment and entered in box #1 of the form. This is a unique number used to identify the adjustment in the Department's files and will be returned on the remittance advice. Department staff will complete boxes 17 through 25 on hospital adjustments and boxes 23 through 37 on NIPS and pharmacy adjustments. The boxes completed by the Department are in bold.


17. Charges (NIPS and Pharmacy) - 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.

Process Type (Hospital/UB billers) – Identifies the type of adjustment processed by the Department staff. The Process Type will be returned on the remittance advice to the provider.

18. TPL (NIPS and Pharmacy) - For Adjustment Type 01, enter the appropriate [TPL code](#) to identify the third party from whom payment was received. TPL information can be found when verifying eligibility on MEDI.

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CAT Service (Hospital/UB billers) – A two-digit entry identifying the category of service under which the original payment was issued.

19. TPL Amount (NIPS and Pharmacy) - 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. 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.

Credit AMT (Hospital/UB billers) - The total amount of credit due to 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.

20. Reason Adjustment Requested (NIPS and Pharmacy) - The provider must enter a clear and concise explanation of the reason the adjustment is being requested.

Debit Amount (Hospital/UB billers) - Additional payment amount approved by the Department as a result of the adjustment action.


21. Provider Signature (NIPS and Pharmacy) - 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 in 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.

Reason Code (Hospital/UB billers) - For Department record keeping only.

22. Date (NIPS and Pharmacy) – The date should reflect the date the adjustment form is signed. This entry may be either handwritten or typed.

Reason Adjustment Made or Denied (Hospital/UB billers) - This is a brief explanation of the Department's approval or denial of the adjustment.

23. **Process Type** - Identifies how the Department has processed the adjustment. It is a two digit number followed by either a "C" for Credit or a "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.

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The Process Type will be reported on the remittance advice. The various process types are described below:

01C (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) a TPL 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 collected by the Department from future payments due the provider.

01D (Debit) TPL - 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 to the provider from the Department.

03C (Credit) or 03D (Debit) - Used when the Department has approved the provider's request for reconsideration.

05C (Credit Only) - 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) - Represents a recoupment. Such credits will be collected by the Department from future payments due to the provider.

09C (Credit) - 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 are collected from future payments due the provider.

09D (Debit) - Used when an additional payment is due to 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 (Per Diem Mass to Detail Credit) - Used 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. 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.

11D (Per Diem Mass to Detail Debit) - Used when the Department is unable to increase a provider's per diem or per visit rate prior to the effective date of a

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Department rate change. 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 (Financial Recovery Credit - Preliminary Fiscal Year Reconciliation Mass) - Used to recoup overpayments based on a preliminary audit of the fiscal year cost report. The amount of the overpayment will be recouped from future payments. This adjustment is used to reconcile payments to providers paid on a per diem basis.

12D (Debit - Preliminary Fiscal Year Reconciliation Mass) - Makes a lump sum payment to a provider based on a preliminary audit of the fiscal year cost report. This adjustment is used to reconcile payments to providers paid on a per diem basis.

13C (Credit - Preliminary Fiscal Year Reconciliation Mass) - 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 providers paid on a per diem basis.

14C (Credit Only) - Used when the provider submits a check representing payment by a third party source.

15C (Financial Recovery Credit - Final Mass) - Used to recoup 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 recouped from future payments. This adjustment is used to reconcile payments to providers paid on a per diem basis.

15D (Debit Fiscal Year Reconciliation-Final Mass) – 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 providers paid on per diem basis.

16C (Credit Only Fiscal Year Reconciliation-Final Mass) - 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 providers paid on a per diem basis.

17C (Third Party Liability Credit) - Initiated when a third party source payment is identified by the Department. The amount of the credit will be recouped from future payments to the provider.

17D (Third Party Liability Debit) - Initiated when the Department determines 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 (Estimated Third Party Liability Credit) - 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.

18D (Debit) - Used when the provider estimated the amount of the TPL and upon adjudication of the claim 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) - 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) - Used when the provider submits a check for a portion of the Department's payment on a single service.

21C (Credit Only) - Used when the Department records of an individual service are to be voided and the amount is to be recouped from future payments to the provider.

22C (Credit) - Signifies a recoupment for a single service. The amount of the credit will be recouped from future payments to the provider.

22D (Debit) - Signifies an additional payment for a single service. The amount of the debit will be added to a future payment to the provider.

25C (Credit Only) - Indicates the return by the provider of a debit the Department issued.


26C (Credit Only) - Indicates the recoupment of a debit the Department issued.

28C (Credit - NIPS and Pharmacy Only) - Informational only. It confirms the receipt of a refund from the patient's third party insurance company. No action is necessary.

32C (Credit Only) - Indicates the receipt of a refund check from the provider for purged services, voided services or services which cannot be identified.

Employee (Hospitals/UB billers) - A three digit number which designates either the Department employee or unit that completed the required data fields.

24. **CAT Service** (NIPS and Pharmacy) - A two digit entry identifying the category of service under which the original payment was issued.

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Date (Hospital/UB billers) - The date on which the adjustment was reviewed.

25. **Credit Amount** (NIPS and Pharmacy) - This is the total amount of credit due to 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 shown here.

Authorized HFS Signature (Hospitals/UB billers) - The signature of the person completing the adjustment action.

26. **Debit Amount** (NIPS and Pharmacy Only) - The additional payment amount approved by the Department as a result of the adjustment action.
27. **CR % - Credit Percent** (Pharmacy) - Used when field 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.

Error Code (NIPS) - For Department record keeping only.

28. **Recoupment Begin Date** (Pharmacy) - Beginning service date for which recoupment (06C) may be applied.

Reason Code (NIPS) - For Department record keeping only.

29. **Recoupment Begin Date** (Pharmacy) - Beginning voucher date for which recoupment (06C) may be applied.

Reason Adjustment Made or Denied (NIPS) - A brief explanation of the Department's approval or denial of the adjustment.

30. **Old Rate** (Pharmacy) - For Department record keeping only.


Employee (NIPS) - A three digit number which designates either the Department employee or unit that completed the required data fields.

31. **New Rate** (Pharmacy) - For Department record keeping only.

Date (NIPS) - The date on which the adjustment was reviewed.

32. **Error Code** (Pharmacy) - For Department record keeping only.

Authorized HFS Signature (NIPS) - The signature of the person completing the adjustment action.

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33. **Reason Code** (Pharmacy Only) - For Department record keeping only.
34. **Reason Adjustment Made or Denied** (Pharmacy Only) - This is a brief explanation of the Department's approval or denial of the adjustment.
35. **Employee** (Pharmacy Only) - A three digit number which designates either the Department employee or unit that completed the required data fields.
36. **Date** (Pharmacy Only) - The date on which the adjustment was reviewed.
37. **Authorized HFS Signature** (Pharmacy Only) - The signature of the person completing the adjustment action.


Self-Disclosure Protocol for All Providers

The mission of the [Department's Office of Inspector General](#) (the OIG) is to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct in the Medical Assistance (Medicaid) program. As part of the multi-disciplinary approach to attaining these goals, the OIG supports health care providers and vendors (providers) who voluntarily self-refer to the provider disclosure protocol upon detection of a violation of Medicaid program requirements resulting in an overpayment from the Department.

The federal [Patient Protection and Affordable Care Act \(ACA\)](#), requires providers to timely identify and repay Medicaid overpayments. Under the ACA, providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. (See 42 U.S.C.A. Section 1320a-7 k (d)). Providers failing to disclose, explain, and repay the overpayment in a timely manner may be subject to liability under the federal False Claims Acts, among other penalties.

While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, it is essential to develop and maintain a fair, reasonable, and consistent process that will be mutually beneficial for both the Department and the provider involved. In order to encourage providers to utilize the self-disclosure protocol, the [OIG](#) offers incentives for providers to investigate and report matters that involve possible fraud, waste, abuse, mismanagement, or misconduct—whether intentional or unintentional—under the Medicaid program. By forming a partnership with providers through this self-disclosure approach, the OIG's mission will be enhanced, while simultaneously offering providers a mechanism that may reduce their legal and financial exposure.

The OIG recognizes that the situations that are appropriate for referral to the self-disclosure protocol could vary significantly; therefore, this protocol is written in general terms to allow providers and the OIG the flexibility to address the unique aspects of the matters disclosed.

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Advantages of Self-Disclosure

Self-disclosure of overpayments will, in most circumstances, result in a better outcome for a provider than if the [OIG](#) discovered the matter independently. While the specific resolution of a self-disclosed matter depends upon the individual merits of the case, the OIG typically extends the following benefits to providers who participate in a self-disclosure in good faith:

- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of some or all applicable penalties and/or sanctions
- Timely resolution of the overpayment Decreased likelihood of imposition of an OIG Corporate Integrity Agreement (CIA)
- If made within 60 days of identification, avoidance of False Claims Act penalties.

Developing a partnership with the OIG during the self-disclosure process may also lead to a better understanding of the OIG's audit and investigatory processes, benefitting the provider in the future.


Determining if Self-Disclosure is Appropriate

Providers should utilize the self-disclosure protocol after the provider fully investigates and confirms that an overpayment exists, or that billings were submitted erroneously even if no overpayment occurred. In addition, providers must be mindful that 42 U.S.C.A Section 1320a-7k(d)(2) requires a provider to self-disclose an overpayment within 60 days of the overpayment being identified or the date that any corresponding cost report is due, if applicable. Failure to report the overpayment in a timely manner subjects the overpayment claims to False Claims Act penalties (\$5,500 to \$11,000 per claim plus three times the amount of damages). However, because of the wide variance in the nature, amount, and frequency of overpayments that may occur, coupled with a wide variety of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Due to the complexity of some issues surrounding self-disclosures, providers may want to obtain the advice of an experienced health care legal counsel or consultant.

Issues appropriate for self-disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of state and federal laws relating to the Medicaid program, such as non-compliance pertaining to documentation and records, quality of care, cost reports, and third party liability.

The protocol is not intended to be used for minor or insignificant matters such as the repayment of simple occurrences of overpayment(s). Repayment of simple overpayments should typically be handled through traditional resolution methods such as voiding or

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adjusting the amounts of claims. The [OIG](#) encourages providers to utilize the self-disclosure protocol when circumstances warrant.

The Disclosure Process

Once a provider determines that disclosure to the [OIG](#) is appropriate, the provider should prepare a written Disclosure Report with the following information, as applicable.

1. Provider information, including name (include doing business as name, or first, middle and last name as name), Medicaid provider identification number, license number, NPI, DEA number, business address, mailing address, telephone number, fax number, and e-mail address.
2. Contact person, if not the provider, and contact information. Specify the relationship of the contact person to the provider.
3. The basis (or bases) for the self-disclosure, including the approximate dates of service covered, the Medicaid recipient identification numbers if available, applicable procedure and/or diagnosis codes affected if applicable, and an assessment of the potential financial impact.
4. Citations to the specific state and federal Medicaid program laws, regulations, rules, policies, guidance, Handbook provisions, and/or other authorities that are or may be implicated.
5. A password protected or otherwise secure Excel or MS Access file with a detailed list of claims paid or submitted that comprise the overpayments. Each claim should list the Medicaid provider identification number, recipient name, Recipient Identification Number (RIN), date(s) of service, procedure code(s) billed, and the amount(s) paid by the Department. For identification purposes, the file/s must be named in accordance with the following format:

NPI Number_SelfD_SubmittingDate.extension (xls/xlsx/mdb)
Examples: 1234567890_SelfD_01012013.xls or xlsx (Excel) **or**
1234567890_SelfD_01012013.mdb (MS Access)
6. Any law enforcement, state, and/or federal agency that has been notified of the same conduct. Include the name, title and contact information of notified individuals and the date of notification.
7. The nature and extent of any investigation or audit conducted by the provider to identify and determine the amount of the overpayment.
8. A summary of the identified underlying cause of the issue(s) involved and any corrective action taken, the date the correction occurred, and the process for monitoring the issue to prevent reoccurrence.

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9. The names of individuals involved in any suspected improper or illegal conduct and whether they are still employed by, or otherwise affiliated with, the provider.
10. An attestation of accuracy and completeness of the Disclosure Report, signed by the provider (if an individual) or an authorized individual (if an organization).

The Disclosure Report (including the password protected or otherwise secure Excel or MS Access File) must be submitted electronically to the following email address:

HFS.OIG.SelfDisclosure@illinois.gov.

The Office of Inspector General will acknowledge receipt of each Self-Disclosure via return email and will contact the appropriate contact person with any questions and/or concerns. No disclosure is complete until the Department receives a complete Self-Disclosure Report.


Assessment of Disclosures

The OIG will consider each disclosed incident on an individual basis. In considering how a disclosure will be brought to conclusion, factors that the [OIG](#) will consider include, but are not limited to:

- The exact issue(s)
- The dollar amount involved
- The percentage of provider's overall Medicaid reimbursement involved
- Any patterns or trends
- The period of non-compliance
- Timely use of the self-disclosure protocol
- The circumstances that led to the non-compliance
- The provider's history with the Department, including recurring overpayments for the same reason
- Whether the provider has a CIA in place

Upon review of the provider's disclosure, the [OIG](#) may independently conclude that the matter warrants referral to the Illinois Attorney General's Medicaid Fraud Control Unit (MFCU) and/or other authorities. Alternatively, the provider may request the participation of a representative of the MFCU, Department of Health and Human Services Office of Inspector General, the Department of Justice, or a local United States Attorney's Office.

Upon review of the provider's disclosure, the [OIG](#) will consult with the provider and determine the most appropriate process for proceeding. The OIG expects the provider to cooperate fully, timely and in good-faith throughout the process. The OIG may request additional information or documentation. The OIG recommends that providers submit all requested and relevant information initially, to lessen the likelihood that additional information will be requested. Assuming that the provider cooperates, the OIG expects that self-disclosures will be handled in a timely manner.

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The OIG will consider the provider’s full, timely, and good-faith cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the OIG cannot reach agreement on the amount of the overpayment, or if a provider fails to cooperate in good-faith, the OIG may pursue the matter through established audit or investigation processes, and the possible advantages of self-disclosure, such as less stringent repayment and/or sanction terms, may no longer apply. Assuming the provider acts in good-faith, the mere fact that the provider and the OIG are unable to agree on a repayment amount will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and the OIG are able to agree.

Relation to Ongoing Audits

Matters related to an ongoing Department audit of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an ongoing audit may be eligible for processing under the protocol. If the OIG is already auditing or investigating the provider, and the provider wishes to avail themselves of the protocol, the provider should bring the matter to the attention of the assigned auditor and make a submission under the protocol. If an outside agency is auditing or investigating the provider for the conduct, and the provider seeks to disclose an issue to the OIG, the provider should follow this guidance accordingly.


Access to Information

Providers are expected to promptly comply with [OIG](#) requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OIG also expects the provider to execute and provide business record certifications, whenever requested, in a form acceptable to the OIG.

The OIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. A provider’s cooperation will be measured by the extent to which a provider (or provider’s counsel) discloses relevant facts and evidence, not its waiver of privilege or protection. However, a lack of information may make it difficult for the OIG to determine the nature and extent of the conduct which caused the overpayment.

Restitution

All provider self-disclosures are subject to independent [OIG](#) review and verification, including determining whether the overpayment amount identified by the provider is accurate. While repayment is accepted throughout the self-disclosure process and repayments will be credited toward the final settlement amount, the OIG will not accept any payment for self-disclosures as full and final payment prior to finalizing its review and verification process.

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Once a repayment amount has been agreed upon between the OIG and the provider, the OIG expects the provider to reimburse the State of Illinois for the overpayment with payment in full or to enter into a repayment agreement if repayment was not previously made.

Vendor Category of Risk

As a result of [Public Act 097-0689](#), referred to as the Save Medicaid Access and Resources Together (SMART) Act, enrollment of a vendor in the Medical Assistance Program (Medicaid) is conditional for one year ([305 ILCS 5/5-5](#)). During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may dis-enroll the vendor from, the Medicaid program without cause. Such termination or disenrollment is not subject to the Department's hearing process. However, a dis-enrolled vendor may reapply without penalty.

The Department is authorized to limit the conditional enrollment period for vendors based upon the risk of fraud, waste, and abuse that is posed by the category of risk of the vendor. The Department defines "high," "moderate," and "limited" vendor categories of risk as:

[High Risk Vendor](#) — Conditional enrollment period of one (1) year

- Transportation (ambulance, medicar, hospital-based, taxicab/livery company, or nonregistered, but excluding private auto)
- Durable Medical Equipment Supplier
- Home health

Moderate Risk Vendor — Conditional enrollment period of one (1) year

- Hospice
- Imaging Center
- Independent Laboratory
- Physical Therapist
- Alcohol and Substance Abuse Provider

Limited Risk Vendor — Conditional enrollment period of nine (9) months

- All vendors that are not defined as either "high" or "moderate" risk

Adjustment in the Category of Risk of a Vendor

The Department may adjust the category of risk level of a specific vendor from "high" or "moderate" risk to "low" risk if, within one (1) year of the date of submission of the vendor's application for enrollment, the vendor has been:

- certified or accredited by Medicare
- issued a CLIA Certificate
- enrolled in good standing in the Medicaid program of a state that borders Illinois

The Department will adjust the category of risk level of a specific vendor from "low" or "moderate" risk to "high" risk if any of the following occur:

- The vendor* has been excluded, denied, suspended, terminated, debarred from, or otherwise sanctioned by Medicaid, Medicare, or any other federal or state healthcare program.
- The vendor* has a delinquent debt owed to the Department.
- At any time during the last 10 years, the vendor* has:
 - been subject to payment suspension by the Department.
 - been precluded from billing Medicaid, Medicare, or any other federal or state healthcare program.
 - had billing privileges revoked by Medicare.
 - been subject to suspension or revocation of a license to provide healthcare by Illinois or any other state's professional licensing authority.
 - been subject to revocation or suspension by an accreditation organization.
 - been convicted of an offense defined in [305 ILCS 5/12-4.25\(A-10\)](#).


During the conditional enrollment period, vendors are subject to enhanced Department oversight, screening, and review based on the category of risk of the vendor.

Type of Oversight, Screening, and Review	Limited Risk Vendor	Moderate Risk Vendor	High Risk Vendor
License/certification/authorization verification	X	X	X
Database checks	X	X	X
Prepayment audit review	X	X	X
Audit	X	X	X
Payment cap	X	X	X
Payment suspension	X	X	X
Unscheduled/unannounced site visit		X	X
Criminal background check**			X
Financial background check**			X
Fingerprinting**			X

The Department is authorized to use additional means of oversight, screening, and review, including as required by federal and state law.

* The vendor or a person with management responsibility for the vendor; an officer of the vendor; a person owning, either directly or indirectly, 5 percent or greater of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship that is a vendor; or a partner in a partnership that is a vendor.

** For all corporate vendors categorized as "high risk," screening activities apply to any person owning, either directly or indirectly, 5 percent or greater of the shares of stock or other evidences of ownership in the vendor. For transportation vendors categorized as "high

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risk," screening activities additionally apply to managers and dispatchers. For individual vendors categorized as "high risk," screening activities apply to the individual.

Cost-Sharing for Participants

Participants covered by Family Care Assist, All Kids Share, All Kids Premium Level I and Level 2, Medicaid adults (SPD) and ACA adults may be charged Department authorized copayments for certain services performed in an office or home setting, pharmacy services, emergency room visits and inpatient/outpatient services.

Certain services and groups of individuals are not subject to copayments. [The Cost-Sharing for Participants chart](#) identifies the eligibility categories, specific procedure codes/services subject to copayments, the copayment amounts and, if applicable, the annual copayment maximum.

Provider Information Sheet Explanation of Information

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.

Field	Explanation
Provider Key	This number uniquely identifies the provider, and is used internally by the Department. It is linked to the reported NPI(s).
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 where the hospital is located. It is also used to identify a 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.
Enrollment Specifics	<p>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:</p> <ul style="list-style-type: none"> 01 = Sole Proprietary 02 = Partnership 03 = Corporation <p>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. Cost report requirements are also indicated. The possible codes are:</p> <ul style="list-style-type: none"> A = Active, Cost Report Required B = Active, Cost Report Not Required

Field	Explanation
	<p>I = Inactive</p> <p>Immediately following the enrollment status indicator are the Begin date indicating when the provider was most recently enrolled in the 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.</p> <p>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:</p> <ul style="list-style-type: none"> A = Intent to Terminate B = Expired License C = Citation to Discover Assets D = Delinquent Child Support E = Provider Review F = Fraud Investigations G = Garnishment I = Indictment L = Student Loan Suspensions R = Intent to Terminate/Recovery T = Tax Levy X = Tax Suspensions <p>If this item is blank, the provider has no exception.</p> <p>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.</p>
Medicare Number	This is the number that the Medicare processing agency uses to identify the hospital.
Categories of Service	This area identifies the types of service a provider is enrolled to provide. Eligibility Category of Service contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs . Each entry is followed by the date on which the provider was approved to render services for each category listed.

Field	Explanation
Payee Information	Records the name and address of the entity authorized to receive payments on behalf of the hospital. The payee is assigned a single-digit Payee Code.
Payee ID	Payee ID Number is a sixteen-digit identification number assigned to each payee, for 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.
NPI	The National Provider Identification Number contained in the Department's database.

Dental

The dental handbook for dental providers is maintained by the Department's dental contractor. The [Dental Office Reference Manual](#) is available on-line or can be requested by phone at 888-281-2076, or by fax at 262-241-7379.

Section 2: Institutional Provider Information

[Hospital Billing Examples](#) are provided for various types of hospital services that may be submitted to the Department. Particular form locators affected and instructions for completion are identified with each scenario.

[Revenue Codes](#) are provided that the Department classifies as non-covered, series-billable, age-restricted, or sex-restricted.

Pricing Calculators for APR DRG and EAPG Reimbursement

For inpatient discharges and outpatient dates of service on and after July 1, 2014, [APR DRG and EAPG pricing calculator spreadsheets](#) are available.

Long Term Care Facility List of Covered Equipment/Supplies

[Long Term Care \(LTC\)](#) facilities are required to provide medical equipment, devices and supplies commonly used in patient care as a part of the per diem reimbursement paid to the facilities by the Department. Such items include, but are not limited to, the following:

Adhesive Tape, Administration Equipment and Supplies for Parenteral Fluids-IV or Subcutaneous (excluding TPN solution and equipment), Alcohol, Alcohol Swabs, Wipes, Antiseptics, Aspirator Bulbs, Atomizers, Band-Aids, Bandages, Bedpans and Urinals, Blood Pressure Kits, Body Lotion, Brushes, Catheters, Combs, Comfort Lotions and Creams, Compression Stockings, Corn Starch, Cotton, Cotton Balls, Swabs, CPAP/BiPAP Machines, Cushions, Non-custom, Dental Floss, Denture Supplies, Deodorant or Antiperspirant, Diabetic Testing Supplies, Diapers, Disposable or Non-disposable, Disinfectants, Disposable Enemas, Drainage Tubing and Receptacles, Dressings, Durable Equipment, Non-custom (e.g., walkers,

wheelchairs), Dusting Powder, Elbow and Heel Protectors, Emesis Basins, Emollients, Enteral Therapy Equipment and Supplies, Eye Patches, Gauzes, Germicides, Hair Conditioner, Hearing Aid Batteries, Heat Lamps, Heavy Duty Equipment (non-custom), Hot Water Bottles, Hydrogen Peroxide, Ice Bags, Irrigation Solutions, IV Poles and Supplies, Lubricating Jelly, Mattress Covers, Mouthwash, Nail Care Supplies, Nebulizers, Orthotics, Non-custom (e.g., helmets, elastic braces), Oximeters and Oxygen Analyzers, Oxygen (1 “H” tank per resident per month) and Equipment/Supplies for Oxygen, Pads (e.g., sheepskin, moleskin), Petroleum Jelly (e.g., Vaseline), Pressure Support Services, Razors, Rectal Tubes, Restraints, Rubber Gloves and Finger Cots, Sanitary Napkins and Related Items, Scissors, Shampoo, Non-prescription, Sharps Collectors, Shaving Cream, Soaps and Soap Substitutes, Suction Catheters, Suction Machine, Suppositories, Syringes and Needles, Talcum Powder, TENS Unit and Supplies, Thermometers, Tissues, Tongue Depressors, Toothbrush, Toothpaste, Towels, Trach Supplies including Trach Care Kits, Urological Supplies, Ventilators, Vinegar Douche

Section 3: Non-institutional Providers (NIPS) Claim Form Instructions

Vaccination Billing Instructions Fee-for-Service (FFS)

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

Example #1

A Well-Child examination and routine vaccinations are administered in a setting other than an encounter rate clinic.

- Bill the examination/visit using the appropriate CPT procedure code
- Bill the specific VFC vaccine procedure code
- Bill the private stock vaccine procedure code for vaccines not offered through VFC.

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific VFC-provided vaccine	Per fee schedule Unit Price field
90xxx	Specific non-VFC vaccine (if applicable)	Per fee schedule State Max field

Example #2

A child presents solely to receive a vaccine in a setting other than an encounter rate clinic. The salaried staff member administers the VFC vaccine and/or private stock vaccine.

- Bill the appropriate outpatient visit for evaluation and management not requiring the presence of a physician
- Bill the specific VFC vaccine procedure code
- Bill the private stock vaccine procedure code for vaccines not offered through VFC

Procedure Code	Description	Reimbursement Rate
99211	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific VFC-provided vaccine	Per fee schedule Unit Price

		field
90xxx	Specific non-VFC vaccine (if applicable)	Per fee schedule State Max field

Children 0 through 18 years of age (Title XXI [21] and State-Funded)

Example #3

A Well-Child examination is performed and routine vaccinations are administered in a setting other than an encounter rate clinic.

- Bill the examination/visit using the appropriate CPT procedure code
- Bill the private stock vaccine using the specific vaccine procedure code. Enter rate for the private stock vaccine plus \$6.40 (*Unit Price*)

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific private stock vaccine	Per fee schedule State Max field plus Unit Price field.

Example #4

A patient presents solely to receive a routine vaccine in a setting other than an encounter rate clinic. The salaried staff member administers the private stock vaccine.

- Bill the appropriate outpatient visit for evaluation and management not requiring the presence of a physician
- Bill the private stock vaccine using the specific vaccine procedure code. Enter rate for the private stock vaccine plus \$6.40 (*Unit Price*)

Procedure Code	Description	Reimbursement Rate
99211	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific private stock vaccine	Per fee schedule State Max field plus Unit Price field.

Vaccine Billing Instructions Encounter Rate Clinics Only

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

Clinics should bill the VFC vaccine as part of a billable visit with the medical encounter procedure code, T1015, or bill the VFC vaccine with the Wellness Visit procedure code, S5190, when a child presents solely for the injection. Shots and immunizations are considered direct access services and do not require a referral.

Example #1

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

- 1st service line, bill the T1015, medical encounter rate procedure code.

- 2nd service line, bill the appropriate level evaluation and management procedure code.
- Subsequent service line(s), bill the specific VFC vaccine procedure code(s).

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

Example #2

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

- 1st service line, bill the T1015, medical encounter rate procedure code.
- 2nd service line, bill the appropriate level evaluation and management procedure code.
- 3rd service line, bill the specific VFC vaccine procedure code.
- 4th service line, bill the private stock vaccine procedure code for vaccines that have never been offered through VFC.

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

Example #3

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

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

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

Example #4

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

- Bill the private stock vaccine procedure code for vaccines that have never been offered through VFC.

Procedure Code	Description	Reimbursement Rate
90xxx	Specific private stock vaccine	\$0

Children 0 through 18 years of age (Title XXI [21] and State-Funded)

Clinics must bill private stock vaccine procedure codes administered to children age 0 through 18 with Title XXI (21) or State-funded eligibility with the **GB** modifier. Clinics can bill private stock vaccines with the GB modifier on a claim separate from the encounter claim, as a detail code with a billable encounter rate procedure code of T1015, or with the Wellness Visit procedure code of S5190 when the participant presents solely to receive a vaccine at the clinic.

- Shots and immunizations are considered *direct access services* and do not require a referral.
- When billing a private stock vaccine as part of an encounter or fee-for-service, clinics must enter a rate as a provider charge on each service line.
- When billing a private stock vaccine that has never been offered through VFC, enter a rate of \$0 as non-VFC vaccines are not paid fee-for-service in an ERC.

Example #5

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

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

Procedure Code	Description	Reimbursement Rate
T1015	All-inclusive clinic/visit medical encounter	Provider specific medical encounter rate
99xxx	Evaluation and Management Code	\$0
90xxx w modifier GB	Specific private stock vaccine	Per fee schedule State Max field; enter a rate for private stock vaccine.

Example #6

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

- 1st service line, bill the T1015, medical encounter rate procedure code
- 2nd service line, bill the appropriate level evaluation and management procedure code
- 3rd service line, bill the private stock vaccine procedure code with the GB modifier
- 4th service line, bill the private stock vaccine procedure code for vaccines that have never been offered through VFC.

Procedure Code	Description	Reimbursement Rate
T1015	All-inclusive clinic/visit medical encounter	Provider-specifics' medical encounter rate
99xxx	Evaluation and Management Code	\$0
90xxx w modifier GB	Specific private stock vaccine	Per fee schedule State Max field; enter a rate for private stock vaccine
90xxx	Specific private stock vaccine	\$0; vaccines never available through VFC are not paid fee-for service.

Example #7

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


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

Procedure Code	Description	Reimbursement Rate
S5190	Wellness Assessment, performed by Non-Physician	\$0
90xxx w modifier GB	Specific private stock vaccine	Per fee schedule State Max field; enter a rate for private stock vaccine

Example #8

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

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

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Procedure Code	Description	Reimbursement Rate
90xxx w modifier GB	Specific private stock vaccine	Per fee schedule State Max field; enter a rate for private stock vaccine.

NIPS Claims NDC Billing Instructions

An NDC is a universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. [The National Drug Code \(NDC\)](#) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

The standard code set for [NDCs](#) is eleven digits. The first segment must include five digits, the second segment must include four digits, and the third segment must include two digits (5-4-2 configuration). For example, 12345-1234-12 is a correctly configured NDC. However, the [NDC](#) on the product label might not contain 11 digits. The labeler may have dropped leading zeros in a segment. In this situation, the appropriate number of leading zeros must be added at the beginning of each segment to ensure that the [NDC](#) is shown in the 5-4-2 format. Where the zero is added depends upon the configuration of the NDC.

The following table provides examples of incorrectly configured NDCs and the corresponding correctly configured NDC. The segment that is missing the leading zero is bolded in each example.

NDC on Label	Configuration on Label	NDC in Required 5-4-2 Format
05678- 123 -01	5-3-2	05678-0123-01
5678 -0123-01	4-4-2	05678-0123-01
05678-0123- 1	5-4-1	05678-0123-01


The following provides [NDC](#) billing instructions for Non-Institutional claims.

HIPAA 837P Transactions and Direct Data Entry through the [MEDI System](#)

For HIPAA 837P electronic claim transactions, the HCPCS Code is reported in Loop ID 2400 and the [NDC](#) is reported in Loop ID 2410. For more detailed information please refer to the billing instructions for electronic claim transactions found in the [Companion Guide](#). Providers registered to bill through the Direct Data Entry [MEDI System](#) can access instructions for the specific claim format.

Paper Transactions

The HCPCS Code with the charge and the appropriate quantity based on the HCPCS definition should be billed on one service line on the [Form HFS 2360](#) (pdf). The corresponding NDC must always be reported on the service line directly after the drug HCPCS Code service line. The [NDC](#) service line(s) must include the date of service, place of service, NDC Code without dashes, and NDC charge amount of zero. On the [Form HFS 3797](#) (pdf), the corresponding NDC must be reported in Section 11.

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Reporting Quantities

At this time, the Department will use only the HCPCS quantities/units for payment and rebate purposes. When a provider uses more than one [NDC](#) of a drug, the provider must include all NDCs on the claim. The quantity for **each** NDC must be reported separately by repeating the HCPCS Code. Please refer to the “**Reporting of Multiple NDCs**” section.

Reporting Charges

The provider’s charge must be reported for each HCPCS Code for both paper claims and electronic transactions. A charge of zero should be reported for each [NDC](#).

Reporting Multiple NDCs

These instructions apply to both paper claims and electronic transactions. At times, it may be necessary for providers to bill multiple NDCs for a single procedure code. This may happen when two different strengths of the same drug are needed in order to administer the appropriate dose. This will also be necessary when multiple vials of the same drug by different manufacturers are used to administer the appropriate dose. Modifiers 51, multiple procedures, and 76, repeat procedure by same practitioner, are to be submitted as necessary. Refer to the billing examples below and the [modifier listing for practitioner claims](#).

Billing examples of these situations are provided below. The examples apply to both paper claims and electronic transactions.

Procedure for billing one HCPCS and multiple NDCs:

- Service Line 1 or Loop 2400: HCPCS Code
Report HCPCS quantity associated with NDC in Service Line 2
- Service Line 2 or Loop 2410: NDC associated with Service Line 1
- Service Line 3 or Loop 2400: HCPCS Code (same as Service Line 1) - Modifier 76 (Repeat Procedure)
Report HCPCS quantity associated with NDC in Service Line 4
- Service Line 4 or Loop 2410: NDC associated with Service Line 3
- Service Line 5 or Loop 2400: HCPCS Code (same as Service Line 1 & 3) - Modifier 51 (Multiple Procedures)
Report HCPCS quantity associated with [NDC](#) in Service Line 6
- Service Line 6 or Loop 2410: NDC associated with Service Line 5

Example 1: Procedure for billing **three (3)** 250 mg vials of ceftriaxone manufactured by two different manufacturers.

Provider will bill a **total quantity of three (3) HCPCS procedure code units**, but will divide those units, as follows:

Service Line 1 or Loop 2400: J0696 billed with a quantity of 2

Service Line 2 or Loop 2410: 00781320695

Service Line 3 or Loop 2400: J0696 and modifier 76 billed with a quantity of 1

Service Line 4 or Loop 2410: 00409733701

Reporting Multiple **NDCs** – Example 1

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0696		Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	Two (2) 250 mg vials	2	00781320695 ceftriaxone 250 mg vial manufactured by Sandoz
J0696	76	Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	One (1) 250 mg vials	1	00409733701 ceftriaxone 250 mg vial manufactured by Hospira

Example 2: Procedure for billing 125 mcg of Aranesp (darbepoetin alfa) using two different vials/strengths of the drug: one (1) 25 mcg syringe and one (1) 100 mcg syringe.

Provider will bill a **total quantity of 125 HCPCS procedure code units**, but will divide those units, as follows:

Service Line 1 or Loop 2400: J0881 billed with a quantity of 25

Service Line 2 or Loop 2410: 55513005704

Service Line 3 or Loop 2400: J0881 with modifier 76 billed with a quantity of 100


Service Line 4 or Loop 2410: 55513002504

Reporting Multiple **NDCs** - Example 2

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0881		Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 25 mcg/ 0.42 ml syringe	25	55513005704 Aranesp 25 mcg/0.42 ml syringe
J0881	76	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 100 mcg/ 0.5 ml syringe	100	55513002504 Aranesp 100 mcg/0.5 ml syringe

NIPS Claims Hand Priced Drug Procedure Codes

These instructions apply to both paper claims and electronic transactions. Providers must report both the HCPCS Code and **NDC** for drugs requiring hand pricing. These procedure

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codes are identified on the [Practitioner Fee Schedule](#). Providers must report the HCPCS Code in the procedure field, and the product name, strength and the dosage administered or dispensed in the description field. The description field is Box 24C on the paper Form HFS 2360 claim, the “procedure literal description” field for DDE claims, or the NTE segment of Loop 2400 for electronic transactions. On paper claims only, the quantity in the units field must be 1. In the service line immediately following, providers must report the [NDC](#) as the procedure code and charge amount as “0.”

Healthy Kids Services

Healthy Kids Services information can be found in [Healthy Kids Handbook](#). The Healthy Kids handbook describes components and frequency that well child screening services are to be performed, in accordance with [Bright Futures, 4th Ed.](#) or subsequent updated guidelines and the medical home model. [The Healthy Kids Services Resource Guide](#) is provided as an additional resource for providers.

Telehealth Billing Examples

Telemedicine Services Billing Examples

Example 1: Originating Site – Physician/APN/Podiatrist’s office
Bill HCPCS Code Q3014

Distant Site – Physician/APN/Podiatrist’s office
Bill the appropriate CPT Code with modifier GT; Place of Service (POS) 02.
Maximum reimbursement will be the fee schedule rate for the CPT Code billed.


Example 2: Originating Site – Local Health Department
Bill HCPCS Code Q3014

Distant Site – Physician/APN/Podiatrist’s office
Bill the appropriate CPT Code with modifier GT; POS 02.
Maximum reimbursement will be the fee schedule rate for the CPT Code billed.

Example 3: Originating Site – Physician/APN/Podiatrist’s office
Bill HCPCS Code Q3014

Distant Site – Local Health Department
Not a valid Distant Site provider – there is no billable service.

Example 4: Originating Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and HCPCS Code Q3014, along with any additional appropriate detail code(s). Maximum reimbursement will be the facility’s medical encounter rate.

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Distant Site – Encounter clinic

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

Example 5: Originating Site – Encounter clinic

Bill the encounter HCPCS Code T1015 and HCPCS Code Q3014, along with any additional appropriate detail code(s). Maximum reimbursement will be the facility's medical encounter rate.

Distant Site – Physician/APN/Podiatrist's office

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

Example 6: Originating Site – Physician/APN/Podiatrist's office

Bill HCPCS Code Q3014

Distant Site – Encounter clinic

Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s); POS 02. Maximum reimbursement will be the facility's medical encounter rate. The rendering provider's name and NPI must also be reported on the claim.

Telepsychiatry Services Billing Examples

Example 1: Originating Site – Physician's office

Bill HCPCS Code Q3014

Distant Site – Physician who has completed an approved general or child/adolescent psychiatry residency program Bill the appropriate CPT Code for services provided, along with Modifier GT; POS 02. Maximum reimbursement will be the fee schedule rate for the CPT Code billed.

Example 2: Originating Site – Encounter clinic

Bill the encounter HCPCS Code T1015 and HCPCS Code Q3014, along with any appropriate detail code(s). Maximum reimbursement will be the facility's medical encounter rate.

Distant Site – Encounter clinic

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

Example 3: Originating Site – Physician's office

Bill HCPCS Code Q3014

Distant Site – Encounter clinic
 Bill the encounter HCPCS Code T1015 and any appropriate detail code(s), along with modifier GT on the detail line(s); POS 02. Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program. Maximum reimbursement will be the facility’s medical encounter rate.

Example 4: Originating Site – Encounter clinic
 Bill the encounter HCPCS Code T1015 and HCPCS Code Q3014, along with any appropriate detail code(s). Maximum reimbursement will be the facility’s medical encounter rate.

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

Anesthesia Payment Formula

General Anesthesia

Anesthesia units	+	(Modifying Units)	+	(Procedure Anesthesia Value)	X	(multiplier)
A	+	B	+	C	X	D

Epidural Anesthesia

Anesthesia units	X	75% (round down)	+	(Procedure Anesthesia Value)	X	(multiplier)
A	X	(.75)	+	C	X	D


A = Anesthesia units. Value is obtained by dividing the number of minutes by minutes per unit. Units are rounded up to the nearest whole number. For non-Medicare primary anesthesia claims, one unit = 12 minutes. For Medicare primary anesthesia claims, one unit = 15 minutes.

Medicare Crossovers

Electronic claims crossed over directly from Medicare to HFS indicate the quantity as the number of 15- minute units.

Electronic crossover claims submitted by the provider are to indicate the quantity modifier in Loop 2400 SV103 as “UN”, units, or “MJ”, minutes and SV104 as the corresponding number of 15-minute units or the number of minutes. Paper crossover claims are to show the quantity as the number of minutes.

HFS multiplies the unit quantity received by 15 minutes per unit to determine the number of minutes. Once the number of minutes is obtained, HFS divides by 12 minutes per unit and then the anesthesia payment formula is followed.

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B = Physical status modifier. HFS-assigned value based on the use these CPT modifiers.

- P1= 0 (old value A)
- P2= 1 (old value B, E)
- P3= 2 (old value C)
- P4= 3 (old value D)
- P5= 4 (old value F)
- P6= 0 (old value G)

C = Anesthesia Value. HFS-assigned value, as shown on [Practitioner Fee Schedule](#).

D = Current multiplier \$15.35

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 Form HFS 1409, Prior Approval Request must be completed. HCPCS polycarbonate lens code V2784 must be the requested procedure code, and the eyeglasses prescription should be listed in Box 21. The [Form HFS 1443](#) Provider Invoice must be completed identifying the procedure code for the dispensing fee. The [Form 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

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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.

Speech Generating Devices Prior Approval Request Guidelines for Durable Medical Equipment Providers

Practitioner Prescription and Certification of Medical Necessity

The augmentative communication speech generating device must be prescribed by the patient's primary care practitioner. Medical necessity must be certified by the primary care practitioner. The certification must document the following:

- The individual lacks the ability to communicate with a practitioner or principal care giver in a manner sufficient to determine the person's care and treatment needs, to determine whether those needs have been met satisfactorily, to prevent or address an emergency medical need, and to prevent or address real or foreseeable injuries or impairments, and
- That intervention will correct a physical deformity or malfunction, or support a weak or deformed part of the body for the purpose of enhancing the individual's ability to communicate medical needs.


It is not required that the practitioner specify the type of device, since that will be determined from the assessment report.

Assessment Report


A patient assessment must be performed by a team led by a speech-language pathologist. The team must include the patient's primary care practitioner and parent (or primary care giver) and other licensed or board-certified medical professionals, as appropriate based on the patient's identified needs.

While there is no prescribed format for the assessment report, it must include the following information as it relates to the patient's ability to communicate:

- A. A brief patient demographic and biographic summary including:
 - Diagnosis and reason for referral
 - Age
 - Approximate physical size

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- Living arrangement (with family and size and composition, in a Long Term Care or group facility, in a Supported Living facility, etc.)
 - Primary patient activities (e.g., school and grade level, employment and type, workshop or day treatment, stays at home) and
 - A list of other supportive resource individuals, if any (e.g., family members, friends, aide at school or work, in-home worker, facility staff).
- B. An inventory of skill levels, sensory function, and use of assistive devices, if any, in the following areas:
- Vision
 - Hearing
 - Ambulation mode(s), including seating and positioning, if applicable
 - Functional gross and fine motor skills in head and neck, trunk, and all four extremities
 - Cognition and learning potential, to include:
 - Cause and effect (ability to associate certain behaviors or events with actions that will follow);
 - Object permanence (ability to remember objects and realize they exist when they are not seen);
 - Means end (ability to anticipate events independent of those currently in progress); and
 - Cognitive level to include any available, recent standard or observational measurements of mental and developmental ages, and demonstrated consistent ability to attend, match, categorize, and sequence.
- C. An inventory of present and future communication skill levels, to include the following:
- Type of expressive communication method or mode(s) used
 - Functional level of oral, written and gestural expressive language capabilities, including oral motor speech status, and the communication functions of requesting, protesting, labeling and sharing information
 - Functional level of receptive communication skills, including language comprehension abilities
 - Communicative interest
 - Identification of a reliable and consistent motor response that can be used independently to communicate and
 - Skill level and use of any equipment aiding in communication including electronic tablets and phones
- D. An explanation of present and future communication needs, including the types of communication needed, with whom and in what environments (for example, to enhance conversation or to write and signal emergency, basic care and related medical needs).
- E. Features needed in patient communication system, as applicable:

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- Type and number of messages, vocabulary size, coding system, symbol sets, message retrieval
- Size, layout, system memory, optical indicators, auditory prompts, rate enhancement, programmability, computer compatibility
- Type of input method (for example, switches, mouth stick, head pointer, alternative keyboard, and direct selection, scanning, encoding)
- Type of output (for example, speech, print, LCD, Braille)
- Mounting and portability
- Extent of training required to use the system and availability of training and technical assistance for its use
- Availability of customer service by manufacturer or supplier and
- Any other relevant considerations.

F. A summary of intervention options, to include:

- A description of the systems tried by the patient during or prior to the assessment and
- The advantages, disadvantages, cost, and availability of training and customer service, for the two or three most appropriate communication systems for the patient as determined through the assessment, specifying available features and patient needs for each.

G. Documentation of patient trial and success, including ability, motivation, independence, and improvement in communication effectiveness, in using one or more recommended communication systems, prior to or during the assessment.


H. The final recommendation of which system is most appropriate to meet the patient's medical needs and why.

Requests must include documentation of a vendor's price quote, a copy of the warranty, the availability of maintenance, the shipping location, and a recommendation of at least one other system which would meet the patient's medical needs. Department approval will be made based on the most cost effective system that meets the individual's medical needs.

Individual Treatment and Implementation Plan

The individual treatment and implementation plan shall identify specific actions, objectives, time lines and the individual(s) responsible to carry out the plan, including programming the communication device, providing training in its use, and monitoring and following-up with the patient to assure appropriate utilization and effectiveness of the device to meet the individual's medical needs. The plan shall also identify the number of orientation or training sessions, and the individuals to be trained (for example, the patient, family, support staff, primary care givers) in the programming and operation of the communication device.

In some instances, when there is a doubt about the patient's ability to use the device that is recommended, the Department may approve rental for a trial period. When a trial period is

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approved, a follow-up assessment from the therapist will be required if the trial period results in a request for purchase of the device.

Replacement, Modifications or Upgrades

Replacement, modification or upgrades of communication devices will require a complete assessment and will be subject to the Department's prior approval policy. Replacements will be approved only if a device is not repairable, is destroyed or stolen, or no longer meets the individual's medical needs. Technological improvements and upgrades are not considered to be repairs and are subject to prior approval.

Section 4: Pharmacy

Pharmacy Benefits Management System

The [Pharmacy Benefits Management System](#) is a real time, point of sale claim adjudication system by which pharmacy providers may submit claims for pharmacy services to the Department. In addition to real time, point of sale claim adjudication, claims may also be submitted through direct data entry.

Pharmacy providers must be enrolled with the Department to submit claims. The [Pharmacy Benefits Management System](#) uses the National Council of Prescription Drugs Program (NCPDP) Version D.0 billing format. See the Department's [payor sheet](#) with detailed billing requirements.

Questions regarding NCPDP should be directed to the National Council of Prescription Drugs Program at 480-734-2870, by fax at 877-647-0295, or pharmacyhelp@ncdpd.org.

Questions regarding the [payor sheets](#) should be directed to the Department's Bureau of Technical Support at 217-524-7288.

Pharmacy Third Party Liability Billing Instructions

Following are instructions for providers who receive Error Code 41 - Submit Bill to Other Processor or Primary Payer.

If the provider does *not* have TPL information for a participant, the provider should ask the participant for their insurance information, or contact the third party to obtain billing information. Once the pharmacy has the billing information, the pharmacy should first bill the third party, and then bill the Department, reporting the third party payment information on the claim.

If the provider believes that the participant does not have other coverage on the date of service, the pharmacy should contact a billing consultant at 877-782-5565.

If the pharmacy has TPL information for the participant for the date of service, and the pharmacy reports an OCC code other than 2, the claim will reject for Error Code 41 - Submit Bill to Other Processor or Primary Payer. If a provider reports OCC 2 Other Coverage Exists – Payment Collected, and the amount reported in field 431 DV Other Payer Amount Paid is illogical relative to the charges reported in field 426 DQ Usual And Customary Charge, the claim will reject. The rejection message will state Verify TPL. If Correct Request PA. If the pharmacy receives this rejection, and the amount reported in field 431 DV Other Payer Amount Paid is accurate, the pharmacy should call the Drug Prior Approval hotline at 800-252-8942.

Following are instructions for providers when an OCC code other than 2 is reported.

OCC - 3 = Other Coverage Exists - This Claim Not Covered

The pharmacy must determine the reason that the medication is not covered by the primary payer before billing the Department. Participants must follow the primary payer's coverage policies and formulary. If the primary payer requires a prior authorization, then the pharmacy must work with the prescriber to complete the necessary documentation to bill the claim to the primary payer. If the claim is for a non-formulary medication, the pharmacy may need to work with the prescriber to switch the prescription to a formulary medication. If the claim is for an injectable medication, the primary payer may require the beneficiary to use a specialty pharmacy mail-order program. In that case, the beneficiary must be referred to the specialty pharmacy program. Only medications that are not covered by the primary payer because of a benefit limitation and which are covered by the Department can be billed to the Department. In this case, the pharmacy should call the Drug Prior Approval hotline at 800-252-8942.


OCC - 4 = Other Coverage Exists - Payment Not Collected

If the primary insurance did not make payment on the claim because the primary payer's benefit design is such that the participant is required to pay the total cost of the claim, e.g., the participant is in the deductible period, the pharmacy should call the prior approval hotline at 800-252-8942.

Medications Subject to the 90 Day Supply Policy for Pharmacy Providers

Generic Name

Acebutolol HCL	Liothyronine Sodium
Amiloride HCL	Lisinopril
Amiloride/Hydrochlorothiazide	Losartan Potassium
Amlodipine Besylate	Metformin HCL
Atenolol	Methyldopa
Atenolol/Chlorthalidone	Methyldopa/Hydrochlorothiazide
Benazepril HCL	Metolazone
Betaxolol HCL	Metoprolol Succinate

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Generic Name

Bisoprolol Fumarate	Metoprolol Tartrate
Bisoprolol Fumarate/HCTZ	Minoxidil
Bumetanide	Moexipril HCL
Captopril	Nadolol
Carvedilol	Nateglinide
Chlorothiazide	Nicardipine HCL
Chlorpropamide	Nifedipine
Clonidine HCL	Perindopril Erbumine
Digoxin	Prazosin HCL
Diltiazem HCL	Propranolol HCL
Doxazosin Mesylate	Quinapril HCL
Enalapril Maleate	Ramipril
Eplerenone	Reserpine
Felodipine	Sotalol HCL
Folic Acid	Spirolact/Hydrochlorothiazide
Fosinopril Sodium	Spirolactone
Furosemide	Terazosin HCL
Glimepiride	Thyroid
Glipizide	Thyroid,Pork
Glipizide/Metformin HCL	Tolazamide
Glyburide	Tolbutamide
Glyburide,Micronized	Torseamide
Glyburide/Metformin HCL	Trandolapril
Guanabenz Acetate	Triamterene/Hydrochlorothiazide
Guanfacine HCL	Verapamil HCL
Hydralazine HCL	
Hydrochlorothiazide	
Indapamide	

Section 5: HFS Paper Claim Form Completion and Technical Guidelines

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

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Handwritten claims will not be accepted for the UB-04. Claims should be computer-printed or typed in capital letters. The character pitch/font size must be 10-12 printed characters per inch.
- Do not leave blank revenue lines within the body of the UB-04 claim. Revenue lines are not to be skipped.

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- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- 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.
- All entries must be within the specified boxes. Do not write outside the box.
- Red ink does not image. Use only black ink for entries on the billing form and attachments. Stamped signatures are not acceptable.
- 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 invoices or fasten attachment with staples.

The left hand column includes a modifier that designates mandatory and optional items for form completion as follows:

- Required = **(R)** - Entry always required.
- Optional = **(O)** - 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 = **(CR)** - Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
- Not Required = **(NR)** - Fields not applicable to the provision of practitioner services.
- * = Denotes differing entries for the field.

Hospital UB-04 Inpatient Requirements

Instructions for completion of the UB-04 claim form follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. For detailed form locator information, all providers should have a copy of the UB-04 Data Specifications Manual for reference. To become a UB-04 Subscriber, refer to the [National Uniform Billing Committee \(NUBC\) website](#).

The UB-04 Data Specifications Manual contains a blank facsimile of the UB-04. Providers may also view a [UB-04 facsimile](#) on the [Department's website](#). For billing purposes, providers must still submit an original UB-04 (no photocopies or laser-printed copies).

Entry	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
R	1	Provider Name – Enter the provider's name exactly as it appears on the Provider Information Sheet.
CR	2	Pay-To Name and Address - Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
O	3a	Patient Control Number
O	3b	Medical Record Number
R	4	Type of Bill – A four-digit field is required. Do not drop the leading zero in this field.
O	5	Fed. Tax No.
R	6	Statement Covers Period
CR	10	Patient Birth Date - If a birth date is entered, the Department will, where possible, correct claims suspended due to patient name and number errors. If a birth date is not entered, the Department will not attempt corrections. A birth date is required only if the claim contains a Type of Admission 4 (newborn).
R	12	Admission Date
CR	13	Admission Hour – An admission hour is required only if the Type of Bill Frequency Code is 1 or 2.
R	14	Priority (Type) of Visit
CR	15	Source of Referral for Admission - Code 4 or D is required when a patient is transferred from another hospital or transferred from hospital inpatient in the same facility, resulting in a separate claim to the payer.
R	17	Patient Discharge Status
CR	18-28	Condition Codes - Required if a condition code applies to this claim, such as C1, C3, AJ, or applicable abortion codes.
CR	31-34	Occurrence Codes and Dates – Refer to the UB-04 Data Specifications Manual for usage requirements.
CR	35-36	Occurrence Span Code/From/Through – When reporting non-covered days, providers must indicate the non-covered date span.
R	39-41	Value Codes – Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter. Value Code 54 – Required to report birth weight in grams of newborns 28 days of age or less on the admission date.

Entry	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
		<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 Form HFS 2432, Split Billing Transmittal, must accompany the claim.</p> <p>Value Code 80 is required for all inpatient claims (the number of days covered by the primary payer). The other value codes below are CR based upon the particular claim.</p> <p>Value Code 81 – The number of days of care not covered by the primary payer. Value Codes applicable to Medicare deductible or coinsurance due.</p>
R	42	Revenue Code – Enter the appropriate revenue code for the service provided. The 23 rd 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.
R	43	Revenue Description
R	44	HCPCS/Accommodation Rates – For accommodation revenue codes, dollar values reported must include whole dollars, the decimal, and the cents. Hospitals are required to bill modifiers according to national coding guidelines.
R	46	Service Units – For each accommodation revenue code, enter the total number of covered days associated with that revenue code. If there are no covered days associated with an accommodation revenue code, the hospital must still enter a “0” (zero) in this field.
R	47	Total Charges (By Revenue Code category) For Revenue Code 0001, see FL 42 above.
CR	48	Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.
R	50	Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort.
CR	51	<p>Health Plan Identification Number</p> <p>HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field, until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. This is required if there is a third party source.</p> <p>TPL Code – The patient's numeric three-digit code must be entered in this field. If payment was received from a third party resource not identified by the Department, enter the appropriate TPL Code as listed in the TPL Code Directory.</p> <p>Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.</p>

Entry	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
		<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 is not in effect.</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> <p>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.</p> <p>99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.</p>
CR	54A,B	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
R	56	National Provider Identifier – Billing Provider. The NPI is the unique identification number assigned to the provider submitting the bill.
O	57	Other (Billing) Provider Identifier Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
R	58	Insured’s Name – Enter the patient’s name exactly as it appears in HFS records.
R	60	Insured’s Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual. Use no punctuation

Entry	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
		or spaces. Do not use the Case Identification Number.
CR	64	Document Control Number – At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
R	67	Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD-10 code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.
CR	67A-Q	Other Diagnosis Codes Enter the specific ICD-10 code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area.
R	69	Admitting Diagnosis Code – Enter the ICD-10 code without the decimal.
CR	70a-c	Patient’s Reason for Visit – This field is required if the claim contains Revenue Code 045X, 0516, 0526, or 0762.
CR	72a-c	External Cause of Injury (ECI) Code – The ICD-10 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
CR	74	Principal Procedure Code and Date - Required if a procedure is performed.
CR	74a-e	Other Procedure Codes and Dates – Required if there were any additional procedures performed.
R	76	Attending Provider Name and Identifiers The Department will adjudicate claims based on the NPI.
CR	77	Operating Physician Name and Identifiers – Required if a surgical procedure is performed. The Department will adjudicate claims based on the NPI.
CR	78-79	Other Provider (Individual) Names and Identifiers –Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.
R	81	Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier “B3” – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Companion Guide , Handbook for Electronic Processing. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Hospital and Ambulatory Surgical Treatment Center UB-04 General Outpatient, ASTC and Outpatient Psychiatric Claim Requirements

Entry	Form Locator	Form Locator Explanation and Instructions for General Outpatient, ASTC, and Outpatient Psychiatric Claims
R	1	Provider Name – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
CR	2	<p>Pay-To Name and Address –Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information.</p> <p>The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.</p>
O	3a	Patient Control Number
O	3b	Medical Record Number
R	4	Type of Bill – A four-digit field is required. Do not drop the leading zero in this field.
O	5	Fed. Tax No.
R	6	Statement Covers Period
O	10	Patient Birth Date - If the birth date is entered, the Department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the Department will not attempt corrections.
CR	18-28	<p>Condition Codes – Condition Code 44 must be used when a hospital admitted a patient for inpatient care, but later determined that an inpatient admission was not medically necessary. The following requirements must be met:</p> <ul style="list-style-type: none"> • The change in patient status from inpatient to outpatient is made prior to discharge of the patient from the hospital. • A new order must be written for outpatient services. <p>Claims containing an abortion procedure need a corresponding abortion condition code.</p>
CR	35-36	Occurrence Span Code/From/Through – When reporting non-covered days, providers must indicate the non-covered date span.
CR	39-41	<p>Value Codes – The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned 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 Form HFS 2432, Split Billing Transmittal, must accompany the claim.</p> <p>Value Code 80 – The number of covered days is required for series</p>

Entry	Form Locator	Form Locator Explanation and Instructions for General Outpatient, ASTC, and Outpatient Psychiatric Claims
		claims. Value Codes applicable to Medicare deductible or coinsurance due.
R	42	Revenue Code – Enter the appropriate revenue code for the service provided. For Psychiatric Clinic Type B services, intensive outpatient program claims should utilize revenue code 0913, and partial hospitalization program claims should utilize revenue code 0912. 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.
R	43	<p>Revenue Description – Refer to the UB-04 Manual for details.</p> <p>NDC reporting of all drug codes is required. When a provider uses more than one NDC for a drug, the provider must include all NDCs on the claim. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting.</p> <ul style="list-style-type: none"> • Report the N4 qualifier in the first two (2) positions, left- justified • Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens) • Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier Codes are as follows: <ul style="list-style-type: none"> • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Unit <ul style="list-style-type: none"> • Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal). • Any spaces unused for the quantity are left blank.
R	44	HCPCS/Accommodation Rates – Claims containing emergency, observation, or psychiatric department services must identify specific procedure codes. Refer to the final page of the APL . Hospitals are required to bill modifiers according to national coding guidelines. Modifier “UD” is required to denote all 340B-purchased drugs. Modifier “UD” must be the first modifier listed after the HCPCS procedure code.
R	45	Service Date
CR	46	Service Units – Claims for the following services must contain an entry: Observation claims must contain the number of hours of observation. Series claims for series-billable revenue codes must contain an entry that

Entry	Form Locator	Form Locator Explanation and Instructions for General Outpatient, ASTC, and Outpatient Psychiatric Claims
		is at least equal to the number of Covered Days.
R	47	Total Charges (By Revenue Code category) For Revenue Code 0001, see FL 42 above.
CR	48	Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.
R	50	Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort
CR	51	<p>Health Plan Identification Number – HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.</p> <p>TPL Code – The patient’s numeric three-digit code must be entered in this field. If payment was received from a third party resource not identified by the Department, enter the appropriate TPL Code as listed in the TPL Code Directory.</p> <p>Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.</p> <p>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. 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, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.</p>

Entry	Form Locator	Form Locator Explanation and Instructions for General Outpatient, ASTC, and Outpatient Psychiatric Claims
		<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> <p>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.</p> <p>99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.</p>
CR	54a,b	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
R	56	National Provider Identifier – Billing Provider The NPI is the unique identification number assigned to the provider submitting the bill.
O	57	Other (Billing) Provider Identifier - Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
R	58	Insured's Name – Enter the patient's name exactly as it appears in Department records.
R	60	Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual. Use no punctuation or spaces. Do not use the Case Identification Number.
CR	64	Document Control Number – At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
R	67	Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD-10 code without the decimal. The POA indicator is not required for outpatient claims.
CR	67a-q	Other Diagnosis Codes - Enter the specific ICD-10 code without the decimal. The POA indicator is not required for outpatient claims.
CR	70a-c	Patient's Reason for Visit – This field is required if the claim contains Revenue Code 045X, 0516, 0526, or 0762.
CR	72a-c	External Cause of Injury (ECI) Code – The ICD-10 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
R	76	Attending Provider Name and Identifiers - The Department will adjudicate claims based on the NPI.
CR	77	Operating Physician Name and Identifiers – Required if a surgical procedure is performed. The Department will adjudicate claims based on the NPI.

Entry	Form Locator	Form Locator Explanation and Instructions for General Outpatient, ASTC, and Outpatient Psychiatric Claims
CR	78-79	Other Provider (Individual) Names and Identifiers –Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.
R	81	Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier “B3” – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Companion Guide , Handbook for Electronic Processing. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

FL 80 - Remarks – HFS utilizes this field to assign each claim’s unique Document Control Number. Providers do not utilize this field.

Renal Dialysis

UB-04 Renal Dialysis Outpatient Claim Requirements

Entry	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
R	1	Provider Name – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
CR	2	Pay-To Name and Address – Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
O	3a	Patient Control Number
O	3b	Medical Record Number
R	4	Type of Bill – A four-digit field is required. Do not drop the leading zero in this field.
O	5	Fed. Tax No.
R	6	Statement Covers Period
O	10	Patient Birth Date - If the birth date is entered, the Department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the Department will not attempt corrections.
R	18-28	Condition Codes - Identify the dialysis place of service. The Department recognizes the following codes: 71-72, 74-76.
CR	35-37	Occurrence Span Code/From/Through – When reporting non-covered days, providers must indicate the non-covered date span.

Entry	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
CR	39-41	Value Codes - The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter. 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 Form HFS 2432, Split Billing Transmittal, must accompany the claim. Value Code 68 – The total units of Epogen must be reported using Value Code 68. Value Code 80 – The number of covered days is required for series claims. Value Codes applicable to Medicare deductible or coinsurance due.
R	42	Revenue Code – Enter the appropriate revenue code for the service provided. If billing series claims, providers must bill individual revenue lines for each dialysis service date. Providers may no longer bill one dialysis revenue line and identify multiple Service Units. 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.
R	43	Revenue Description - NDC reporting of all drug codes is required. When a provider uses more than one NDC for a drug, the provider must include all NDCs on the claim. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting. <ul style="list-style-type: none"> • Report the N4 qualifier in the first two (2) positions, left-justified • Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens) • Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows: <ul style="list-style-type: none"> • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Unit <ul style="list-style-type: none"> • Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal). • Any spaces unused for the quantity are left blank.
R	44	HCPCS/Accommodation Rates – Enter the corresponding HCPCS code associated with Revenue Lines 0634, 0635, or 0636. Hospitals are required to bill modifiers according to national coding guidelines. Modifier “UD” is required to denote all 340B-purchased drugs. Modifier “UD” must be the first modifier listed after the HCPCS procedure code.
R	45	Service Date - Dialysis revenue codes and injectable drug revenue codes

Entry	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
		0634, 0635, and 0636 require a separate service line for each date of service.
CR	46	<p>Service Units – An entry is required to correspond to each renal dialysis revenue code. Also, an entry is required for claims containing Revenue Codes 0634 and 0635 for Epogen, or Revenue Code 0636 for specified renal dialysis injectable drugs. Units should not be combined for multiple dates of service.</p> <p>For Epogen, the numeric units' value, by definition of HCPCS code Q4081, should be 1/100 of the numeric units value identified in FL 39.</p>
R	47	<p>Total Charges (By Revenue Code category)</p> <p>For dates of service beginning February 1, 2013, providers may add a \$12.00 dispensing fee to the actual acquisition cost for a drug from the Renal Dialysis Injectable Drug Listing if that drug is 340B-purchased. For Revenue Code 0001, see FL 42 above.</p>
CR	48	Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.
R	50	Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort.
CR	51	<p>Health Plan Identification Number – HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.</p> <p>TPL Code –The patient's numeric three-digit code must be entered in this field. If payment was received from a third party resource not identified by the Department, enter the appropriate TPL Code as listed in the TPL Code Directory.</p> <p>Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.</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</p>

Entry	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
		<p>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> <p>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.</p> <p>99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.</p>
CR	54a-b	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
R	56	National Provider Identifier – Billing Provider. The NPI is the unique identification number assigned to the provider submitting the bill.
O	57	Other (Billing) Provider Identifier. Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
R	58	Insured's Name – Enter the patient's name exactly as it appears in Department records.
R	60	Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown in Department records. Use no punctuation or spaces. Do not use the Case Identification Number.
CR	64	Document Control Number – At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
R	67	Principal Diagnosis Code and Present on Admission (POA) Indicator – Enter the specific ICD-10 code without the decimal. The POA indicator is not required for renal dialysis claims.
CR	67A-Q	Other Diagnosis Codes – Enter the specific ICD-10 code without the decimal. The POA indicator is not required for renal dialysis claims.
CR	72A-C	External Cause of Injury (ECI) Code – The ICD-10 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

Entry	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
R	76	Attending Provider Name and Identifiers – The Department will adjudicate claims based on the NPI.
R	78-79	Other Provider (Individual) Names and Identifiers - Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.
R	81	Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier “B3” – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Companion Guide , Handbook for Electronic Processing. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Birth Center

UB-04 Birth Center Claim Requirements

Entry	Form Locator	Form Locator Explanation and Instructions for Outpatient Birth Center Claims
R	1	Provider Name – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
CR	2	Pay-To Name and Address – Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
O	3a	Patient Control Number
O	3b	Medical Record Number
R	4	Type of Bill – A four-digit field is required. The only valid Type of Bill for birth centers is 0841. Do not drop the leading zero in this field.
O	5	Fed. Tax No.
R	6	Statement Covers Period
O	10	Patient Birth Date - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.
CR	18-28	Condition Codes
CR	35-36	Occurrence Span Code/From/Through – When reporting non-covered days, providers must indicate the non-covered date span.
CR	39-41	Value Codes – 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 Form HFS 2432, Split Billing Transmittal, must accompany the claim.
R	42	Revenue Code – Enter the appropriate revenue code for the service

Entry	Form Locator	Form Locator Explanation and Instructions for Outpatient Birth Center Claims
		<p>provided.</p> <p>0724 – Birthing Center. For delivery and transfer services.</p> <p>0762 – Observation Hours. For observation services.</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>
R	43	Revenue Description - Refer to the UB-04 Manual for details.
R	44	HCPCS/Accommodation Rates – Claims must contain a valid procedure code for the service(s) rendered. Refer to the Birth Center Fee Schedule for covered codes.
O	45	Service Date – If a date is entered, it will be edited.
CR	46	Service Units – Claims for observation services must contain an entry. Observation claims must contain the number of hours of observation.
R	47	Total Charges (By Revenue Code category) For Revenue Code 0001, see FL 42 above.
CR	48	Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.
R	50	Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort
CR	51	<p>Health Plan Identification Number – HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the 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.</p> <p>Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.</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</p>

Entry	Form Locator	Form Locator Explanation and Instructions for Outpatient Birth Center Claims
		<p>patient informs the provider that the third party resource identified on the MediPlan Card 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> <p>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.</p> <p>99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.</p>
CR	54A,B	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
R	56	National Provider Identifier – Billing Provider Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.
O	57	Other (Billing) Provider Identifier - Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.
R	58	Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.
R	60	Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do not use the Case Identification Number.
CR	64	Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
R	67	Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD diagnosis code without the decimal. The POA indicator is not required for birth center claims.
CR	67A-Q	Other Diagnosis Codes - Enter the specific ICD diagnosis code without the

Entry	Form Locator	Form Locator Explanation and Instructions for Outpatient Birth Center Claims
		decimal. The POA indicator is not required for birth center claims.
CR	72A-C	External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
R	76	Attending Provider Name and Identifiers - For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.
CR	78-79	Other Provider (Individual) Names and Identifiers –Refer to the UB-04 Data Specifications Manual for usage requirements.
R	81	Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier “B3” – Healthcare Provider Taxonomy Code. Birth centers must use designated taxonomy code 241QB0400X. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

FL 80 - Remarks – HFS utilizes this field to assign each claim’s unique Document Control Number. Providers do not utilize this field

Hospice

UB-04 Hospice Claim Requirements

Entry	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
R	1	Provider Name – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
CR	2	Pay-To Name and Address – Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-to Address is required when the address for payment is different than that of the Billing Provider in FL 1.
O	3a	Patient Control Number
O	3b	Medical Record Number
R	4	Type of Bill – A 4-digit field is required. Do not drop the leading zero in this field.
O	5	Fed. Tax No.
R	6	Statement Covers Period
O	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.
R	12	Admission Date
R	17	Patient Discharge Status
CR	35-36	Occurrence Span Code/From/Through – Indicate the non-covered date

Entry	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
R	39-41	<p>span.</p> <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: Value Code 81 – The number of days of care not covered by the primary payer. 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. 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. 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>
R	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>
R	43	Revenue Description
R	44	<p>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.</p>
CR	45	<p>Service Date – Each service date for Revenue Code 0652, Revenue Code 055X, and Revenue Code 056X must be reported on separate Revenue Code lines. Each of these Revenue Code lines requires a date. The date</p>

Entry	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
		<p>cannot be repeated and must fall within the From and Through dates. If a date for any other hospice revenue code is reported, it must fall within the From and Through dates in FL 6.</p> <p>Any SIA date must be tied to a date for RHC in order to be reimbursed. Revenue code 0651 (RHC) associated with an SIA day, plus revenue codes 055X (registered nurse service) and/or 056X (social work service), must be billed by individual service date. If there are no SIA days associated with specific RHC days, RHC revenue code 0651 may be billed for multiple service units (FL 46).</p>
CR	51	<p>Health Plan Identification Number 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</p>

Entry	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
		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.
CR	54A,B	Prior Payments – TPL payments are identified on lines A and B to correspond to any insurance source in FL 51 lines A and B.
R	56	National Provider Identifier – Billing Provider The NPI is the unique identification number assigned to the provider submitting the bill.
O	57	Other (Billing) Provider Identifier – Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
R	58	Insured's Name – Enter the patient's name exactly as it appears on HFS records.
R	60	Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual. Use no punctuation or spaces. Do not use the Case Identification Number.
CR	64	Document Control Number – At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
R	67	Principal Diagnosis Code and Present on Admission Indicator – Enter the specific ICD-10 code without the decimal. A POA indicator is not required for hospice claims.
CR	67A-Q	Other Diagnosis Codes – Enter the specific ICD-10 code without the decimal. A POA indicator is not required for hospice claims.
R	69	Admitting Diagnosis Code – Enter the specific ICD-10 code without the decimal.
CR	72A-C	External Cause of Injury (ECI) Code – The ICD-10 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
R	76	Attending Provider Name and Identifiers – The Department will adjudicate claims based on the NPI.
R	81	Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Companion Guide for Electronic Processing, available on the Department's website. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

*Additional notes

Form Locator 80 Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Non Institutional Provider Claim Forms

Form [HFS 1443](#), **Provider Invoice** for Audiology, Chiropractic, Local Education Agencies, Optometry, Podiatry, and Therapy - R = Required; NR = Not Required; CR = Conditionally Required; O = Optional; * Denotes differing entries for the field.

Entry	Item	Item Explanation and Instructions
R	1	Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet.
R	2	Provider Number - Enter the National Provider Identifier (NPI) number.
R	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.
*	4	Role – Not Required for Audiology, Chiropractic, Optometry, Therapy, or LEA. Required for Podiatry Claims.
NR	5	Emer – Leave blank.
*	6	Prior Approval – Not Required for Audiology, Chiropractic, LEA, or Optometry. Conditionally Required for Podiatry and Therapy
O	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.
CR	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). For Audiology and LEAs, it is CR when the Place of Service Code is other than 11 (office) or 12 (home).
*	9	Provider City State ZIP – Enter city, state and ZIP code of provider. See item 7 above. Optional for Audiology, Chiropractic, LEA, Optometry, and Podiatry. Required for Therapy claims.
*	10	Referring Practitioner Name – Not Required for Chiropractic or Optometry, Conditionally Required for LEA and Podiatry. Required for Audiology and Therapy.
R	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.
R	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.
O	13	Birth Date – Enter the month, day and year of birth of the patient. 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 blank, the Department will not attempt corrections.
NR	14	H Kids – Leave Blank
NR	15	Fam Plan – Leave Blank.
NR	16	St/Ab – Leave Blank.
R	17	Primary Diagnosis Description - Enter the primary diagnosis that describes the condition primarily responsible for the patient's treatment.
R	18	Primary Diag. Code - Enter the specific ICD-10 without the decimal for the

Entry	Item	Item Explanation and Instructions
		primary diagnosis described in Item 17.
R	19	Taxonomy - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to the Taxonomy for 837P table .
O	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.
*	21	Ref Prac No. – Not Required for Chiropractic or Optometry. Conditionally Required for LEA and Podiatry. Required for Audiology and Therapy.
*	22	Secondary Diagnosis Code – Not Required for Audiology, Optometry and Therapy. Optional for Chiropractic, LEA and Podiatry.
	23	Service Sections – Complete one Service Section for each item or service provided to the patient.
R	23 Cont'd	Procedure Description/Drug Name, Form and Strength or Size – Enter the description of the service provided or item dispensed.
R	23 Cont'd	Proc. Code/NDC – Enter the appropriate CPT or HCPCS code.
*	23 Cont'd	Modifiers – Enter the appropriate two-byte modifier(s) for the service performed. The Department can accept a maximum of 4 two-byte modifiers per service section. Not Required for Optometry. Conditionally Required for Audiology, Chiropractic, LEA, and Podiatry. Required for Therapy: GP – Physical Therapy, GO – Occupational Therapy, GN – Speech Therapy
R	23 Cont'd	Date of Service – Enter the date the service was provided. Use MMDDYY format.
R	23 Cont'd	Cat. Serv. – Enter the appropriate two-digit category of service code. 03 - Optometric, 04 - Podiatry, 45 - Optometric Supplies, 05 - Chiropractic, 11 – Physical Therapy, 12 – Occupational Therapy, 13 – Speech Therapy, 014 - Audiology
CR	23 Cont'd	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.
*	23 Cont'd	Place of Serv. – Enter the two-digit Place of Service code from the following: 11 – Office – Audiology, Chiropractic, LEA, Optometry, Podiatry, Therapy 12 – Home - Audiology, Chiropractic, LEA, Optometry, Podiatry, Therapy 13 – Assisted Living Facility – Audiology, Chiropractic, Optometry, Podiatry, Therapy 14 – Group Home - Audiology, Chiropractic, Optometry, Podiatry, Therapy 19 – Off Campus Outpatient Hospital - Audiology, Therapy 21 - Inpatient Hospital - Audiology, Podiatry 22 - On Campus Outpatient Hospital – Audiology, Podiatry, Therapy 31 – Skilled Nursing Facility – Audiology, Chiropractic, Optometry, Podiatry 32 – Nursing Facility – Audiology, Chiropractic, Optometry, Podiatry 33 – Custodial Care Facility - Audiology, Chiropractic, Optometry, Podiatry, Therapy

Entry	Item	Item Explanation and Instructions
*	23 Cont'd	Units/Quantity – Not Required for Chiropractic, LEA, Optometry, Podiatry, or Therapy. Conditionally Required for Audiology.
NR	23 Cont'd	Modifying Units – Leave Blank.
CR	23 Cont'd	<p>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.</p> <p>Do not report Medicare Information in the TPL fields.</p> <p>For Medicare denied services with an additional TPL resource involved:</p> <ul style="list-style-type: none"> • 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.
CR	23 Cont'd	<p>TPL Entries for Spenddown - The following provides examples: When the date of service is the same as the "Spenddown Met" date on the Form HFS 2432 (Split Billing Transmittal), the Form HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.</p> <p>If the Form HFS 2432 shows a participant liability greater than \$0.00, the fields should be coded as follows:</p> <p style="margin-left: 40px;">TPL Code 906 TPL Status 01 TPL Amount is the actual participant liability shown on Form HFS 2432. TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>If the Form HFS 2432 shows a participant liability of \$0.00, the fields should be coded as follows:</p> <p style="margin-left: 40px;">TPL Code 906 TPL Status 04 TPL Amount 00 TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>If the Form 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:</p> <p>Claim 1</p> <p style="margin-left: 40px;">TPL Code 906 TPL Status 01 TPL Amount is the actual participant liability up to total charges. TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>Claim 2</p>

Entry	Item	Item Explanation and Instructions
		<p>TPL Code 906</p> <p>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.</p> <p>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.</p> <p>TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p>
		<p>If Form 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:</p> <p>Claim 1</p> <p>TPL Code 906</p> <p>TPL Status 04</p> <p>TPL Amount 000</p> <p>TPL Date is the issue date on the bottom right corner of the HFS 2432.</p> <p>Claim 2</p> <p>TPL Code 906</p> <p>TPL Status 04</p> <p>TPL Amount 000</p> <p>TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>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 Form HFS 2432 attached and must be mailed to a consultant for special handling.</p>
CR	23 Cont'd	<p>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.</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 the services provided are not covered.</p> <p>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.</p> <p>05 - Patient not covered: TPL Status Code 05 is to be entered when the</p>

Entry	Item	Item Explanation and Instructions																		
		<p>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, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.</p> <p>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.</p>																		
CR	23 Cont'd	<p>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.</p>																		
CR	23 Cont'd	<p>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:</p> <table border="0"> <tr> <td>Code</td> <td>Date to be entered</td> </tr> <tr> <td>01</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>02</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>03</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>04</td> <td>Date from Form HFS 2432</td> </tr> <tr> <td>05</td> <td>Date of Service</td> </tr> <tr> <td>06</td> <td>Date of Service</td> </tr> <tr> <td>07</td> <td>Date of Service</td> </tr> <tr> <td>10</td> <td>Third Party Adjudication Date</td> </tr> </table>	Code	Date to be entered	01	Third Party Adjudication Date	02	Third Party Adjudication Date	03	Third Party Adjudication Date	04	Date from Form HFS 2432	05	Date of Service	06	Date of Service	07	Date of Service	10	Third Party Adjudication Date
Code	Date to be entered																			
01	Third Party Adjudication Date																			
02	Third Party Adjudication Date																			
03	Third Party Adjudication Date																			
04	Date from Form HFS 2432																			
05	Date of Service																			
06	Date of Service																			
07	Date of Service																			
10	Third Party Adjudication Date																			
R	23 Cont'd	<p>Provider Charge - Enter the total charge for the service, not deducting any third party liability.</p>																		
NR	24	<p>Optical Materials Only – Leave Blank. When ordering lenses and/or frames, complete Form HFS 2803, Optical Prescription Order. Attach Form HFS 2803 to Form HFS 1443 Provider Invoice and submit both forms to the HFS, P.O. Box 19105 Springfield, Illinois 62794-9105.</p>																		
<p>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.</p>																				
CR	25	<p>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.</p>																		

Entry	Item	Item Explanation and Instructions
CR	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.
CR	25B	Status – Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.
CR	25C	TPL Amount – Enter the amount of payment received from the third party resource.
CR	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.
CR	26	Sect # - Enter (see 25 above).
CR	26A	TPL Code – (See 25A above).
CR	26B	Status – (See 25B above).
CR	26C	TPL Amount – (See 25C above).
CR	26D	TPL Date – (See 25D above).
CR	27	Sect #. – (See 25 above).
CR	27A	TPL Code – (See 25A above).
CR	27B	Status – (See 25B above).
CR	27C	TPL Amount – (See 25C above).
CR	27D	TPL Date – (See 25D above).
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.		
R	28	Tot Charge – Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
R	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).
R	30	Net Charge – Enter the difference between Total Charge and Total Deductions.
R	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.
NR	32	Original DCN – Leave Blank.
NR	33	Sect. – Leave Blank.
NR	34	Bill Type - Leave Blank.
CR	35	Uncoded TPL Name – Enter the name of the third party resource. The name must be entered if TPL code 999 is used.
R	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.

[Form HFS 2209 \(pdf\), Transportation Invoice](#)

Entry	Item	Explanation and Instructions
R	1	Provider Name – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
R	2	Provider Number – Non-Emergency Transportation Providers- Enter the provider number exactly as it appears on the Provider Information Sheet. Emergency Transportation Providers – Enter the NPI number.
R	3	Billing Date – Enter the date the Transportation Invoice was prepared. Use the six-digit, MMDDYY format.
O	4	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 the provider copy of Form HFS 194-M-1, Remittance Advice.
O	5	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 eligibility errors. If address is not entered, the Department will not attempt corrections.
O	6	Provider City, State, ZIP – Enter the city, state and ZIP code of provider. (See Item 5 above)
R	7	Recipient Name (First, MI, Last) – Enter the participant’s name. Separate the name (first, middle initial, last name) by leaving one space between each component. Enter the first name beginning at the left margin of the box.
R	8	Recipient Identification Number (RIN) – Enter the nine-digit RIN. Do not use the Case Identification Number.
R	9	Birth date – Use the six-digit, MMDDYY format.
R	10	Vehicle License Number – Enter the vehicle license plate number of the vehicle used for this trip. This field applies to emergency and non-emergency services. (Include alpha characters if they are part of the license number.)
	11	Service Sections (1 through 8) – One Service Section is to be completed for each procedure code billed. Do not leave a Service Section blank between two completed Service Sections. Providers may complete from one (1) to eight (8) Service Sections per invoice according to the number of services provided.
R		Date of Service – Enter the date that the transportation service was provided. (MMDDYY) Multiple dates of service may be billed on the same invoice.
R		Category of Service (Cat Serv) – Enter the appropriate code from the list below. 50 - Emergency Ambulance or Helicopter 51 - Non-emergency Ambulance 52 - Medicar 53 - Taxicab 54 - Service Car 55 - Private Automobile 56 - Other
R		Procedure Code – For services requiring prior approval, enter the “Approved Procedure Code.” For services that do not require prior approval, enter the appropriate code from the provider information sheet.

Entry	Item	Explanation and Instructions
CR		Prior Approval Number – This field is required for non-emergency transportation claims.
R		Origin Time – Enter the time the loaded trip began. Time is to be entered as Military Time (if the loaded trip began at 1:30 p.m., the time would be shown as 1330).
R		Destination Time – Enter the time the loaded trip ended at the destination. Time is to be entered as Military Time.
CR		Total Loaded Miles – Enter the total loaded miles one way. When a round trip is provided, two mileage procedure codes and Service Sections must be completed. Miles are to be rounded up to the nearest mile (e.g., 11.4 miles is rounded “12”). Billing for excess mileage is not allowed.
R		Provider Charge – Enter the provider’s usual and customary charge for the procedure code shown in this section. Separate dollars and cents in the proper sections of the field.
CR		Delete – When an error has been made that cannot be corrected, enter a single capital “X” to delete the entire Service Section.
R		Origin Place – Enter the appropriate HCPCS modifier selected from the list below as shown on the prior approval letter. P - Physician’s Office D - Medical Service (other than P or H) H - Hospital (Inpatient or Outpatient) R - Residence
R		Origin (Facility Name/City or Address/City) – Enter the facility name or origin place address and the city from which the patient was transported. The origin may be a hospital, clinic, long-term care facility, the patient’s home address or other location.
R		Destination Place – Enter the appropriate HCPCS modifier selected from the list below as shown on the prior approval letter. P – Physician’s Office D – Medical Service (other than P or H) H – Hospital (Inpatient or Outpatient) R - Residence
R		Destination (Facility Name/City or Address/City) – Enter facility name or destination place address and the city to which the patient was transported. The destination may be a hospital, clinic, long-term care facility, the patient’s home address, etc.
CR	12	TPL Code – When the patient has a Third Party Liability (TPL) , the code is to be entered in this field. If two TPL Codes are listed, both codes are to be entered in this field: If TPL codes are not applicable, enter Code “999” and the name of the payment source in Field 13, Uncoded TPL Name. If there is no third party liability resource, no entries are to be made in Fields 12 and 13.
CR		SPENDDOWN – If the patient has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form HFS 2432 (Split Billing Transmittal). When a Form HFS 2432 is necessary, Form HFS 2209, Transportation Invoice, should be completed as follows:

Entry	Item	Explanation and Instructions
CR		<ul style="list-style-type: none"> • Enter 906 in the TPL CODE field. • Enter a 01 in the TPL Status field if there is a patient liability or enter a 04 in the TPL STATUS field if there is no patient liability. • From the Form HFS 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form 2209. This amount may be \$0.00. • From the Form HFS 2432, enter the DATE from the bottom of the form in the TPL DATE field of the Form HFS 2209. • The TPL fields must be completed in each Service Section that has the same date of service as the Split Bill day. The Spenddown liability is to be divided and reported to the TPL AMOUNT field of each Service Section that has the same date of service. <p>Status – A two-digit code indicating the disposition of the third party billing must be entered. No entry is required if no third party liability exists. 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 goods or services were provided.</p> <p>03 - TPL Adjudicated - service not covered: TPL Status Code 03 is to be entered when advised by the third party resource that goods or services provided are not covered.</p> <p>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 liability.</p> <p>05 - Patient not covered: TPL Status Code 05 is to be entered when the patient informs the provider that the third party liability 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 an invoice 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 - Not Assigned</p> <p>09 - Not Assigned</p> <p>10 - Deductible not met (Medicare excluded): TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that no payment was made for the service because the patient's deductible was not met.</p>

Entry	Item	Explanation and Instructions
CR	13	Uncoded TPL Name – Enter the name of any third party payor coded 999 in the TPL Code field. If two third parties have issued payment for a service, the names of both parties are to be entered.
R	14	Number of Sections – Enter the number of Service Sections completed correctly on the invoice.
R	15	Total Charge – Enter the sum of all Provider Charges submitted on the invoice.
CR	16	Total Deductions – Enter the sum of all TPL payments received. If no payments were received, leave blank.
R	17	Net Charge – Enter the difference between the total charge and total deductions.
R	18	Signature of Provider/Date – After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered in MMDDYY format and may be handwritten, typewritten or computer printed.

Form [HFS 2210](#), Medical Equipment/Supplies Invoice

Entry	Item	Item Explanation and Instructions
R	1	Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet.
R	2	Provider Number - Enter the National Provider Identifier (NPI) number.
R	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.
R	4	Billing Date – Enter the date the claim form was prepared.
O	5	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 the HFS 194-M-2, Remittance Advice , returned to the provider.
O	6	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 eligibility errors. If address is not entered, the Department will not attempt corrections.
O	7	Provider City, State, ZIP - Enter city, state and ZIP code of provider address. See Item 6 above.
	8	Service Sections – The form provides five service sections to list the specific items for which reimbursement is being requested. These service sections can be used to bill up to five items for the same patient. Claims with an attachment may only identify one date of service. At least one service section must be completed, as follows:
R		Recipient Name (First, MI, Last) - Enter the patient's name. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
R		Recipient No. - Enter the nine digit number assigned to the individual. Do not

Entry	Item	Item Explanation and Instructions
		use punctuation or spaces. Do not use the Case Identification Number.
O		Birth date - Enter the month, day and year of birth of the patient.
CR		Accident/Injury - When applicable, enter one of the following codes to indicate the nature of any accident or injury that necessitated the patient's need for the medical equipment or supplies: 1 - A work-related accident or illness 2 - A motor vehicle accident 3 - Participation in an organized sport or school activity 4 - An act of violence (non-accidental) 5 - An unspecified accident
NR		Healthy Kids – Leave Blank
NR		Cr. Child – Leave Blank
CR		Delete - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.
R		Diagnosis Description - Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient's need for the items.
NR		Prefix -. Do not use this field for the ICD-10 diagnosis code set.
R		Diag. Code - Enter the primary diagnosis code exactly as it appears in the ICD-10 manual. For ICD-10 diagnosis codes, this field will contain both the alpha and numeric characters of the diagnosis code. Do not enter the decimal point.
R		Ordering Practitioner Name (First, Last) - Enter the name of the practitioner who determined the need for the item dispensed.
R		Ordering Practitioner Number - Enter the ordering practitioner's NPI.
NR		Order Number - Leave blank.
CR		Prior Approval - If the item requires prior approval, enter the last eight digits of the Prior Approval Number from Form HFS 3076A, Prior Approval Notification Letter.
R		Cat. Serv. - Enter the appropriate two-digit category of service (COS) code: 41 Medical Equipment or Prosthetic Devices 48 Medical Supplies The COS code for each item is identified in the DME Fee Schedule on the Department's website .
R		Item - Enter the appropriate five-digit HCPCS code for the item dispensed.
R		Purchase/Rent - Enter one purchase/rental code as follows: For COS 41, Medical Equipment/Prosthetic Devices 1 =Purchase 2 =Rental 3 =Repair 4 = Modification 5 =Loaner For COS 48, Medical Supplies



Entry	Item	Item Explanation and Instructions
		1 =Purchase
R		Quantity - Determine the standard unit for the item, and complete this field based on the amount dispensed, expressed in the standard units defined for this item. The standard unit is generally one (1). Exceptions are identified in the reimbursement listings on the Department's website .
R		Date of Service - Enter the date the service or item was provided to the patient.
CR		TPL Code - If payment was received from a third party resource, enter the appropriate three-digit TPL code. Do not enter the lead alpha character. Do not enter the TPL code for Medicare. Enter Code 999 and the name of the payment source in Field 9, "Uncoded TPL Name", if unknown. If more than one third party made a payment for a particular service or item, list the second company in Field 9, "Uncoded TPL Name" (and include both dollar amounts in the TPL amount).
		<p>TPL Entries for Spenddown. The following provides examples: When the date of service is the same as the "Spenddown Met" date on Form HFS 2432 (Split Billing Transmittal), Form HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form 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 is the actual participant liability as shown on Form HFS 2432. TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>If Form 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 is the issue date on the bottom right corner of Form HFS 2432.</p> <p>If Form 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 is the actual participant liability up to total charges. TPL Date is the issue date on the bottom right corner of Form HFS 2432. Claim 2 TPL Code 906 TPL Status 01 if remaining liability from Claim 1 is greater than \$0.00 or 04</p>

Entry	Item	Item Explanation and Instructions
		<p>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 recipient liability after Claim 1. If status code 04 was used in Claim 2 status field, enter 000. TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p>
		<p>If Form 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:</p> <p>Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of Form HFS 2432.</p> <p>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 Form HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions Section in the All Providers Handbook Supplement.</p>
CR		<p>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.</p> <p>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 items or 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, 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</p>

Entry	Item	Item Explanation and Instructions
		<p>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, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.</p> <p>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.</p>
CR		<p>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. If there is no TPL code, no entry is required.</p>
CR		<p>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:</p> <p>Code Date to be entered</p> <p>01 - Third Party Adjudication Date</p> <p>02 - Third Party Adjudication Date</p> <p>03 - Third Party Adjudication Date</p> <p>04 - Date from the HFS 2432</p> <p>05 - Date of Service</p> <p>06 - Date of Service</p> <p>07 - Date of Service</p> <p>10 - Third Party Adjudication Date</p>
R		<p>Provider Charge - Enter the total charge for the Service Section, not deducting any third party liability.</p>
CR		<p>Repeat - This box appears only in Service Sections 2-5. It may be used when two or more Service Sections are for items supplied to the same patient. When an X is entered in this box, all information in the preceding Service Section will be repeated in the Department's claim system, except Date of Service and the TPL fields.</p> <p>If the items dispensed are identical except for Date of Service, the only entries required are an X in the Repeat box and the new Date of Service. If different items are dispensed to the same patient, entries are also required in any fields that differ from the preceding Service Section.</p> <p>The Repeat box may not be used following a Service Section that has been deleted.</p>
CR	9	<p>Uncoded TPL Name - If TPL code 999 was used in any of the completed Service Sections, the name of the third party health resource must be entered in this field.</p>
CR	12	<p>Sect. # - If more than one third party made a payment for a particular service, enter the Service Section number (1-5) in which that service is reported.</p>
CR	13A	<p>TPL Code - Refer to the instructions for TPL Code above.</p>
CR	13B	<p>Status - Refer to the instructions for Status above.</p>
CR	13C	<p>TPL Amount - Refer to the instructions for TPL Amount above.</p>

Entry	Item	Item Explanation and Instructions
CR	13D	TPL Date - Refer to the instructions for TPL Date above.
R	14	# Sects. - Enter the number of Service Sections completed on this claim. Use a single digit number only. Do not count Service Sections that have been deleted.
R	15	Total Charge - Enter the sum of all charges submitted on this claim in Service Sections 1-5.
CR	16	Total Deductions - Enter the sum of all payments received from other sources. If no payment was received, leave blank.
R	17	Net Charge - Enter the difference between Total Charge and Total Deductions.
R		Provider Certification, Signature and Date - After reading the certification statement, the provider or authorized 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. The signature date is to be entered.

[Form HFS 2211](#), Laboratory/Portable X-Ray Invoice

Entry	Item	Item Explanation and Instructions
R	1	Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet.
R	2	Provider Number – Enter the National Provider Identifier (NPI) number.
CR	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. If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
NR	4	Group – Leave blank.
NR	5	Role – Leave blank.
NR	6	Acc/Inj – Leave blank.
O	7	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 HFS 194-M-2, Remittance Advice , returned to the provider.
O	8	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 eligibility errors. If address is not entered, the Department will not attempt corrections.
CR	9	Facility & City Where Service Rendered – This entry is required when Place of Service Code is other than J (laboratory).
NR	10	Prior Approval – Leave blank.
O	11	Provider City, State, ZIP – Enter city, state and ZIP code of provider. See Item 8 above.
R	12	Referring Practitioner Name – Name of practitioner ordering test.

Entry	Item	Item Explanation and Instructions
R	13	Ref Prac No – Enter the referring practitioner’s National Provider Identifier (NPI) number.
R	14	Recipient Name – Enter the patient’s name exactly as it appears in HFS records. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
R	15	Recipient No – Enter the nine-digit number assigned to the individual. Do not use punctuation or spaces. Do not use the Case Identification Number.
O	16	Birth date – Enter the month, day and year of birth of the patient. 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.
NR	17	Healthy Kids – Leave blank.
NR	18	Fam Plan – Leave blank.
NR	19	Cr Child – Leave blank.
NR	20	St/Ab – Leave blank.
R	21	Billing Date – Enter the date the invoice was prepared.
R	22	Primary Diagnosis Description – Enter the primary diagnosis which describes the condition primarily responsible for the patient’s treatment.
NR	23	Prefix
R	24	Diag Code – Enter the primary ICD-10 diagnosis code. This field will contain both the alpha and numeric characters of the diagnosis code. Do not enter the decimal point.
NR	25	Secondary Diagnosis – Leave blank.
NR	26	Prefix – Leave blank.
NR	27	Diag. Code – Leave blank.
	28	Service Sections – Complete one service section for each item or service provided to the patient.
R		Procedure Description – Enter the appropriate description of the service provided.
R		Proc Code – Enter the appropriate five-digit procedure code.
CR		Delete – When an error has been made that cannot be corrected, enter an “X” to delete the entire service section. Only “X” will be recognized as a valid character; all others will be ignored.
R		Date of Service – Enter the date the service was performed.
R		Cat Serv – Enter 43 to identify laboratory services as the category of service.
R		Place of Serv – Enter the one letter Place of Service Code from the following list: Code: Place of Service: H Long Term Care Facility I Shelter Care J Laboratory K Patient’s Home
CR		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

Entry	Item	Item Explanation and Instructions
		<p>eligibility verification for the three-digit TPL code.</p> <p>Spenddown – The following provides examples: When the date of service is the same as the “Spenddown Met” date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form HFS 2432 shows a participant liability greater than \$0.00, the invoice should be coded as follows:</p> <p>TPL Code 906 TPL Status 01 TPL Amount The actual participant liability as shown on Form HFS 2432 TPL Date The issue date on the bottom right corner of the HFS 2432. If Form HFS 2432 shows a participant liability of \$0.00, the invoice should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 0 00 TPL Date The issue date on the bottom right corner of the HFS 2432.</p>
CR		<p>Status – If a TPL code is shown in section 28, 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>04 - TPL Adjudicated - spenddown met: TPL status code 04 is to be entered when the patient's Form HFS 2432 shows \$0.00 liability.</p> <p>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.</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, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain</p>

Entry	Item	Item Explanation and Instructions
		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.
CR		TPL Amount – If there is no TPL code, no entry is required. 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.
CR		Adjudication Date – A TPL date is required when any status code is shown in section 28. 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
R		Provider Charge – Enter the total charge for the service, not deducting any payment from the third party resource.
CR		Repeat – Place X in box if the same service is performed on an additional date of service.
CR		Charges and Deductions Section – The information field in the lower right of the HFS 2211 is to be used: 1). To identify additional third party resources in instances where the patient has access to two or more resources, 2). To identify uncoded TPL carriers by name, and 3). To calculate total and net charges. If a second third-party resource was identified for one or more of the services billed in service sections 1 through 7 of the HFS 2211 , complete the TPL fields in accordance with the following instructions:
CR		Sect # – If more than one third party made a payment for a particular service, enter the service section number (1-7) in which that service is reported. If a third party resource 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 this section will be applied to the total of all service sections on the invoice.
CR		TPL Code – Enter the appropriate TPL Resource Code. If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.
CR		Status – Enter the appropriate TPL Status code. See Item 28 for correct coding of this field.
CR		TPL Amount – Enter the amount of payment received from the third party resource.

Entry	Item	Item Explanation and Instructions
CR		Adjudication Date – Enter the date the claim was adjudicated by the third party resource. See Item 28 for correct coding of this field.
CR		Uncoded TPL Name – Enter the name of the third party health resource. The name must be entered if TPL code 999 is used. The three claim summary fields must be completed on all invoices. These fields are Total Charge, Total Deductions, and Net Charge and are located at the bottom right of the form in Item 30.
R		Total Charge – Enter the sum of all charges submitted on the invoice in service sections 1 through 7.
R		Total Deductions – Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).
R		Net Charge – Enter the difference between Total Charge and Total Deductions fields.
R		# Sects – Enter the number of Service Sections completed correctly in the top part of the form. This entry must be at least one and not more than 7. Do not count any service sections that were deleted.
NR		Original DCN – Leave blank.
NR		Original Voucher Number – Leave blank.
R		Provider Certification, Signature and Date – After reading the certification statement, the provider 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.

Form [HFS 2212 \(pdf\)](#), Health Agency Invoice

Entry	Item	Explanation and Instructions
R	1	Provider Name – Enter the provider’s name exactly as it appears on the Provider Information Sheet.
R	2	Provider Number – Enter the NPI number.
R	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. If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
NR	4	Group – Leave blank.
NR	5	Role – Leave blank.
CR	6	Acc/Inj – When applicable enter one of the following codes to indicate the probable reason the participant sought treatment: 1 - Employment related accident or illness. 2 - Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle. 3 - Injury due to participation in an organized sport or school activity. 4 - Injury due to an act of violence (non-accidental).

Entry	Item	Explanation and Instructions
		5 - Injury is the result of an unspecified accident.
O	7	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 HFS-194-M-2, Remittance Advice , returned to the provider.
O	8	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 eligibility errors. If the address is not entered, the Department will not attempt corrections.
CR	9	Facility & City Where Service Rendered – This entry is required when Place of Service Code is other than 12 (patient’s home).
CR	10	Prior Approval – This entry is required when reporting a qualifying hospital discharge date. The participant’s hospital discharge date is reported in 8 digit format (MMDDYYYY format). *Do not enter the prior approval number. Leave blank if there is no applicable hospital discharge date.
O	11	Provider City State Zip – Enter city, state and zip code of provider address. See item 8 above.
R	12	Referring Practitioner Name – Name of referring physician.
R	13	Ref Prac No. – Enter the referring physician’s NPI.
R	14	Recipient Name – Enter the participant’s name exactly as it appears on HFS records. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. Do not use punctuation between the names.
R	15	Recipient No. – Enter the nine-digit number assigned to the participant. Do not use the Case Identification Number.
CR	16	Birth date – Enter the month, day and year of birth of the participant. 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.
NR	17	Healthy Kids – Leave blank.
NR	18	Fam Plan – Leave blank.
NR	19	Cr Child – Leave blank.
NR	20	St/Ab – Leave blank.
R	21	Billing Date – Enter the date the invoice was prepared.
R	22	Primary Diagnosis Description – Enter the primary ICD-10 diagnosis description that describes the condition primarily responsible for the participant’s treatment.
NR	23	Prefix
R	24	Diag Code – Enter the primary ICD-10 diagnosis code. For ICD-10 diagnosis codes, this field will contain both the alpha and numeric characters of the diagnosis code. Do not enter the decimal point.
CR	25	Secondary Diagnosis – When treatment is the result of dissimilar conditions, the diagnosis description from the ICD-10 for the secondary diagnosis is entered.
CR	26	Prefix –.
CR	27	Diag Code – Enter the secondary ICD-10 diagnosis code. For ICD-10 diagnosis codes, this field will contain both the alpha and numeric characters of the

Entry	Item	Explanation and Instructions												
		diagnosis code. Do not enter the decimal point.												
	28	Service Sections Complete one service section per date of service for each service provided to the participant.												
R		Procedure Description - Enter the appropriate description of the service provided.												
CR		Procedure Code – Enter the appropriate five-digit procedure code. Modifier U2 – Report the 2-byte modifier immediately following the procedure code to designate an initial skilled nurse assessment visit or the initial therapy evaluation visit.												
CR		Delete - When an error has been made that cannot be corrected, enter an “X” to delete the entire service section. Only “X” will be recognized as a valid character; all others will be ignored.												
R		Date of Service – Enter the date the service was performed using the 6 digit, MMDDYY, format.												
R		Cat. Serv. -Enter 66 – Home Health Services.												
R		Place of Serv – Enter the appropriate two digit Place of Service Code: Code: Place of Service: <table border="1" data-bbox="349 934 941 1155"> <tr> <td>04</td> <td>Homeless Shelter</td> </tr> <tr> <td>12</td> <td>Home</td> </tr> <tr> <td>13</td> <td>Assisted Living</td> </tr> <tr> <td>14</td> <td>Group Home</td> </tr> <tr> <td>32</td> <td>Nursing Facility</td> </tr> <tr> <td>33</td> <td>Custodial Care Facility</td> </tr> </table>	04	Homeless Shelter	12	Home	13	Assisted Living	14	Group Home	32	Nursing Facility	33	Custodial Care Facility
04	Homeless Shelter													
12	Home													
13	Assisted Living													
14	Group Home													
32	Nursing Facility													
33	Custodial Care Facility													
R		Units - Enter the number of visits per day.												
CR		TPL Code - If payment was received from a third party resource, enter the appropriate TPL Code. Do not include the leading alpha character.												
		Spendedown – The following provides examples: When the date of service is the same as the “Spendedown 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 Status01 TPL Amount is the actual participant liability as shown on the HFS 2432 TPL Date is the issue date on the bottom right corner of the HFS 2432. 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 is the issue date on the bottom right corner of the HFS 2432.												
CR		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.												

Entry	Item	Explanation and Instructions																		
		<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 participant’s third party resource. The amount of payment received must be entered in the TPL amount box.</p> <p>02 – TPL Adjudicated – participant not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the participant 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>04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the participant’s HFS 2432 shows \$0.00 liability.</p> <p>05 – Participant not covered: TPL Status Code 05 is to be entered when a participant informs the provider that the third party resource identified in MEDI 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, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed.</p> <p>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.</p>																		
CR		TPL Amount - Enter the amount of payment received from the third party resource. A dollar amount entry is required if TPL Status Code 01 was entered in the “Status” field. For TPL Status Codes 02-10, enter 000. If there is no TPL code, no entry is required.																		
CR		<p>TPL Date - Required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status Code:</p> <table border="0"> <tr> <td>Code</td> <td>Date to be entered</td> </tr> <tr> <td>01</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>02</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>03</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>04</td> <td>Date from the HFS 2432, Split Bill Transmittal</td> </tr> <tr> <td>05</td> <td>Date of Service</td> </tr> <tr> <td>06</td> <td>Date of Service</td> </tr> <tr> <td>07</td> <td>Date of Service</td> </tr> <tr> <td>10</td> <td>Third Party Adjudication Date</td> </tr> </table>	Code	Date to be entered	01	Third Party Adjudication Date	02	Third Party Adjudication Date	03	Third Party Adjudication Date	04	Date from the HFS 2432, Split Bill Transmittal	05	Date of Service	06	Date of Service	07	Date of Service	10	Third Party Adjudication Date
Code	Date to be entered																			
01	Third Party Adjudication Date																			
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04	Date from the HFS 2432, Split Bill Transmittal																			
05	Date of Service																			
06	Date of Service																			
07	Date of Service																			
10	Third Party Adjudication Date																			
R		Provider Charge - Enter the total charge for the service, not deducting any TPL.																		
CR		Repeat - Place “X” if the service is done on the next date.																		
NR	29	Shaded Area – Leave blank.																		
	30	Charges and Deductions Section – The information field in the lower right of the HFS 2212 (pdf) is to be used: 1) to identify additional third party resources in instances where the participant has access to two or more resources; 2) to identify																		

Entry	Item	Explanation and Instructions
		uncoded TPL carriers by name, and; 3) to calculate total and net charges. If a second third party resource was identified for one or more of the services billed in Services Section 1 through 7, complete the TPL field in accordance with the following instructions:
CR		Sect. # - If more than one third party made a payment for a particular service, enter the Service Section number (1 through 7) in which that service is reported. If a third party resource 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 this section will be applied to the total of all Service Sections on the Invoice.
CR		TPL Code - Enter 999 and enter the name of the payment source in the Uncoded TPL Name field if unknown.
CR		Status - Enter the appropriate TPL Status Code. See Item 28 for correct coding of this field.
CR		TPL Amount - Enter the amount of payment received from the third party resource.
CR		Adjudication Date - Enter the date the claim was adjudicated by the third party resource.
CR		Uncoded TPL Name - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

The following three claim summary fields must be completed on all invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom right of the [HFS 2212 \(pdf\)](#).

Entry	Item	Explanation and Instructions
R		Total Charge - Enter the sum of all charges submitted on the invoice in Service Sections 1 through 7.
R		Total Deductions - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).
R		Net Charge - Enter the difference between Total Charge and Total Deductions fields.
R	31	# Sects – Enter the total number of Service Sections completed correctly in the top part of the form. This entry must be at least one (1) and not more than seven (7). Do not count any sections that were deleted.
NR	32	Original DCN – Leave blank.
NR	33	Original Voucher Number – Leave blank.
R		After reading the certification statement, the provider or an 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. Unsigned Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

Form [HFS 2360 \(pdf\)](#), Health Insurance Claim Form

Entry	Item	Explanation and Instructions
R	1	Patient's Name - Enter the participant's name exactly as it appears on the

Entry	Item	Explanation and Instructions
		Identification Card or Notice. Separate the components of the name (first, middle initial, last) in the proper order of the name field.
O	2	Patient's Date of Birth - Enter the month, day and year of birth of the patient. If the birthdate is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birthdate is not entered, the Department will not attempt corrections. Age – leave blank.
NR	3-7	Leave blank.
R	8	Medicaid Number – Enter the nine-digit number assigned to the individual. Use no punctuation or spaces. Do not use the Case Identification Number.
NR	9	Other Health Insurance Coverage – Leave blank.
CR	10	Was Condition Related to – If the patient sought treatment for an injury or illness that resulted from employment, type a capital “X” in the Yes box under A, Patient's Employment. If the patient sought treatment for an injury or a condition that resulted from an automobile accident, type a capital “X” in Field 10B, AUTO. If the place of service billed is for Emergency Department Services, type a capital “X” in Field 10B, OTHER.
NR	11	Insured's Address – Leave blank.
R	12	Recipient's or Authorized Person's Signature – The participant or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. If the signature is on file, enter the statement “Signature on File” here.
NR	13	Leave blank.
CR	14	For prenatal services, enter the date of the Last Menstrual Period (LMP).
NR	15	Leave blank.
CR	16	Check here if emergency.
NR	17-18	Leave blank.
CR	19	Name of Referring Practitioner or Other Source – This field is required when charges are being submitted for a consultation. Additionally, a referring practitioner's name is always required when a referring practitioner NPI is entered. Referring Practitioner Number – The referring practitioner number is always required when a referring practitioner name is entered. Enter the referring practitioner's NPI.
NR	20	Leave blank
CR	21	Facility Where Services Rendered - This entry is required when Place of Service Code in Field 24B is other than 11 (office) or 12 (home). Address may be abbreviated.
NR	22	Leave blank.
CR	23A	Healthy Kids Services - If services rendered were Healthy Kids services, enter a capital X in the Yes box.
CR	23B	Family Planning - If services were rendered for family planning purposes, enter a capital X in the Yes box.
CR	23C	Sterilization/Abortion - If services rendered were for a Sterilization or

Entry	Item	Explanation and Instructions
		<p>Abortion, enter a capital X in the Yes box.</p> <p>When the service is being submitted for payment for an abortion, a completed copy of the HFS 2390 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope.</p> <p>When the service is being submitted for payment for sterilization, a completed copy of the HFS 2189 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope.</p> <p>When the service is being submitted for payment for a hysterectomy, a completed copy of HFS 1977 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope.</p>
NR	23D	Prior Approval – Leave blank.
R	23E	<p>T.O.S. (Type of Service) – Enter the code corresponding to the type of service for which the charges submitted on the claim apply. Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. The following are the Type of Service Codes acceptable by the Department.</p> <ol style="list-style-type: none"> 1 Medical Care – Attending Physician or Concurrent Care. 2 Surgery – Surgeon, Assistant Surgeon or Co-Surgeon. 3 Consultation – Consultant. 4 Diagnostic X-Ray – Radiologist. 5 Diagnostic Laboratory – Pathologist. 7 Anesthesia –Anesthesiologist, CRNA 8 Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon.
O	23F	Diagnosis or Nature of Injury or Illness – Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient’s treatment. A written description is not required if a valid ICD-10 Code is entered in Item 24D.
O	24	<p>Repeat – The practitioner may use the repeat indicator to complete the same data fields in multiple service sections. All information other than the date of service must remain the same as the previous service section. The actual date of service must be entered in every service section. When the repeat box is necessary, enter a capital “X.” Any other character will be ignored. The repeat indicator cannot be used immediately following a service section which has been deleted.</p>
R	24A	Date of Service - Enter the date the service was rendered.
R	24B	P.O.S. (Place of Service) – Enter the 2-digit code corresponding to the appropriate place of service.
R	24C	Procedure Code/Drug Item No. - Enter appropriate procedure code or NDC .
CR	24C	MOD – Enter the appropriate two-character modifier for the service performed. A listing of the modifiers recognized in processing HFS claims may be found on the modifier listing for practitioner claims.

Entry	Item	Explanation and Instructions
R	24D	Primary Diagnosis Code – Enter the specific ICD-10 Code without the punctuation or spaces for the primary diagnosis.
O	24D	Secondary Diagnosis Code – A secondary diagnosis may be entered. Enter only a specific ICD-10 Code without the punctuation or spaces.
R	24E	Charges – Enter the total charge, in both dollars and cents, for the service. Do not deduct any Third Party Liability payments or copayments from these charges.
R	24F	Days/Units – Unless otherwise stated or allowed enter a quantity of “0001.” A four-digit entry other than “0001” is required for the following: <ul style="list-style-type: none"> Anesthesia Service, enter the duration of time in minutes; e.g., the entry for 1 hour and 10 minutes is 0070. Assistant Surgeon services, enter the duration of time in minutes; e.g., the entry for 1 hour and 10 minutes is 0070. When billing for multiples refer to the practitioner fee schedule key.
O		Delete - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
R	25	Signature of Physician and Date Signed - After reading the certification statement printed on the back of the claim form, the practitioner or authorized biller (practitioner’s name followed by biller’s initials) must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the practitioner when possible. The practitioner’s signature should not enter the date section of this field.
R	26	Accept Assignment – The practitioner must accept assignment of Medicare benefits for services provided to participants. Enter a capital “X” in the "Yes" box.
R	27	Total Charges - Enter the sum of all charges submitted on the claim in service section 1 through 7. Do not include charges for any deleted sections.
R	28	Amount Paid - Enter the sum of all payments received from other sources. The entry must equal the sum of the amounts as shown in fields 37C and 38C, TPL Amount. If no payment was received enter three zeroes (000). Do not collect primary copayments on Medicaid secondary claims. Do not include HFS copayments or amount previously paid by the Department as primary payment.
R	29	Balance Due - Enter the difference between Total Charges and Amount Paid.
R	30	Your Provider Number – Enter the rendering practitioner’s NPI.
R	31	Provider Name, Address, ZIP Code – Enter the practitioner’s name exactly as it appears on the Provider Information Sheet. Enter the street address of the practitioner. If an address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If an address is not entered, the Department will not

Entry	Item	Explanation and Instructions
		attempt to make corrections. Enter city, state and zip code of practitioner.
O	32	Your Patient's Account Number - Enter up to 20 numbers or letters used in your accounting system for identification. If this field is completed, the same data will be reported on the HFS 194-M-2, Remittance Advice .
R	33	Your Payee Code – Enter the one-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
R	34	Number of Sections - Enter the number of service lines correctly completed above in Section 24. Do not include deleted sections.
NR	35-36	Leave blank.
CR	37a	<p>TPL Code –The numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed in MEDI, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in 38A. – 38D. Do not attach a copy of the TPL Explanation of Benefits (EOB).</p> <p>Practitioners providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a patient's private insurance carrier prior to billing the Department for these services. Do not report Medicare Information in the TPL fields.</p> <p>For Medicare denied services with an additional TPL resource involved, please report the following:</p> <ul style="list-style-type: none"> • Do not report the Medicare information in the TPL field. • Do attach a copy of the Medicare EOB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOB.
		<p>Spenddown – The following provides examples:</p> <p>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.</p> <p>If the HFS 2432 shows a participant liability greater than \$0.00, the fields should be coded as follows:</p> <p>TPL Code 906 TPL Status 01 TPL Amount is the actual participant liability as shown on the HFS 2432 TPL Date is the issue date on the bottom right corner of the HFS 2432.</p> <p>If the HFS 2432 shows a participant liability of \$0.00, the fields should be coded as follows:</p> <p>TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of the HFS form 2432</p>

Entry	Item	Explanation and Instructions
CR	37a	<p>If the HFS 2432 shows a participant liability of greater than \$0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows:</p> <p>Claim 1 TPL Code 906 TPL Status 01 TPL Amount is the actual participant liability up to total charges TPL Date is the issue date on the bottom right corner of the HFS 2432</p> <p>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 is the issue date on the bottom right corner of the HFS 2432.</p> <p>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:</p> <p>Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of the HFS 2432..</p> <p>Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of the HFS 2432.</p> <p>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.</p>
CR	37b	<p>TPL Status – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are:</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 practitioner 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 practitioner is advised by the third party resource that</p>

Entry	Item	Explanation and Instructions																		
		<p>services provided are not covered.</p> <p>04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient’s HFS 2432 shows \$0.00 liability.</p> <p>05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force.</p> <p>06 – Services not covered: TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided.</p> <p>07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed.</p> <p>10 – Deductible not met: TPL Status Code 10 is to be entered when the practitioner has been informed by the third party resource that non-payment of the service was because the deductible was not met.</p>																		
CR	37c	TPL Amount – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the “Status” field.																		
CR	37d	<p>TPL Date – A TPL date is required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status Code:</p> <table border="0"> <tr> <td>Code</td> <td>Date to be entered</td> </tr> <tr> <td>01</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>02</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>03</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>04</td> <td>Date from the HFS 2432, Split Bill Transmittal</td> </tr> <tr> <td>05</td> <td>Date of Service</td> </tr> <tr> <td>06</td> <td>Date of Service</td> </tr> <tr> <td>07</td> <td>Date of Service</td> </tr> <tr> <td>10</td> <td>Third Party Adjudication Date</td> </tr> </table>	Code	Date to be entered	01	Third Party Adjudication Date	02	Third Party Adjudication Date	03	Third Party Adjudication Date	04	Date from the HFS 2432, Split Bill Transmittal	05	Date of Service	06	Date of Service	07	Date of Service	10	Third Party Adjudication Date
Code	Date to be entered																			
01	Third Party Adjudication Date																			
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03	Third Party Adjudication Date																			
04	Date from the HFS 2432, Split Bill Transmittal																			
05	Date of Service																			
06	Date of Service																			
07	Date of Service																			
10	Third Party Adjudication Date																			
CR	38a	TPL Code – (See 37A above).																		
CR	38b	TPL Status – (See 37B above).																		
CR	38c	TPL Amount – (See 37C above).																		
CR	38d	TPL Date – (See 37D above).																		

[Form HFS 3797 \(pdf\), Medicare Crossover Invoice](#)

Entry	Item	Explanation and Instructions
R		<p>Claim Type – Enter a capital “X” in the appropriate box, using the following guideline when determining claim type:</p> <p>23 - Practitioner - physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers</p> <p>24 - Dental - dental providers</p> <p>25 - Lab/Port X-Ray - all laboratories and portable X-ray providers</p> <p>26 - Med. Equip/Supply - medical equipment and supply providers, pharmacies</p>

		28 - Transportation - ambulance service providers If provider type is not indicated above, enter a capital "X" in the Practitioner box.
R	1	Recipient's Name - Enter the participant's name (first, middle, last).
R	2	Recipient's Birth date - Enter the month, day and year of birth. (MMDDYY).
R	3	Recipient's Sex – Enter a capital "X" in the appropriate box.
CR	4	Was Condition Related to –
	A	Participant'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.
R	5	Recipient's Medicaid Number – Enter the individual's assigned nine-digit number. Do not use the Case Identification Number.
R	6	Medicare HIC (Health Insurance Claim) Number – Enter the Medicare Health Insurance Claim Number (HICN).
R	7	Recipient's Relation to Insured – Enter a capital "X" in the appropriate box.
R	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 practitioner/supplier. If the signature is on file, enter the statement "Signature on File" here.
CR	9	Other Health Insurance Information - If the participant has an additional health benefit plan (other than Medicare or Medicaid), enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.
R	10A	Date(s) of Service - Enter the date(s) of service submitted to Medicare. Using the MMDDYY format enter the same date in both the "From" and "To" fields.
R	10B	P.O.S. (Place of Service) – Enter the two-digit POS Code submitted to Medicare. Excludes Transportation.
R	10C	T.O.S. (Type of Service) – Enter TOS as submitted to Medicare. The following are the Type of Service Codes acceptable by the Department. Excludes Transportation and Durable Medical Equipment. 1 Medical Care – Attending Physician or Concurrent Care. 2 Surgery – Surgeon, Assistant Surgeon or Co-Surgeon. 3 Consultation – Consultant. 4 Diagnostic X-Ray – Radiologist. 5 Diagnostic Laboratory – Pathologist. 7 Anesthesia Anesthesiologist, CRNA 8 Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon.
R	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.
R	10E	Procedure Code - Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
R	10F	Amount Allowed – Enter the amount allowed by Medicare for the service(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
R	10G	Deductible – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
R	10H	Coinsurance – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
R	10I	Provider Paid – Enter the amount the practitioner was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
CR	11	For NDC Use Only – Required when billing NDC Codes for practitioner purchased and administered injectable medication.
CR	12	For Modifier Use Only – Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB). Excludes Transportation.
R	13A	Origin of Service – Required for transportation only. Enter the facility name or origin place address and city from which the patient was transported.
R	13B	Modifier – Required for transportation only. Enter the first alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).
R	14A	Destination of Service – Required for transportation only. Enter the facility name or destination place address and city from which the patient was transported.
R	14B	Modifier – Enter the second alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).
NR	15A	Origin of Service – Leave blank.
NR	15B	Modifier – Leave blank.
NR	16A	Destination of Service – Leave blank.
NR	16B	Modifier – Leave blank.
O	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 the HFS 194-M-2, Remittance Advice , returned to the provider.
CR	18	Diagnosis or Nature of Injury or Illness - Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-10 Code is entered in Field 18A.
R	18A	Primary Diagnosis Code – Enter the valid ICD-10 Diagnosis Code without punctuation or spaces for the services rendered.
O	18B	Secondary Diagnosis Code – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-10 Diagnosis Code without punctuation or spaces.
R	19	Medicare Payment Date – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). (MMDDYY)
CR	20	Name and Address of Facility Where Services Rendered - This entry is required when Place of Service (10B) is other than practitioner's office or participant's home. Enter the facility name and address where the service(s) was rendered. When the name and address of the facility where the services were rendered is

		the same as the biller's name and address as submitted in Field 22, enter the word "Same."
R	21	Accept Assignment – The practitioner 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.
R	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."
R	23	HFS Provider Number – Enter the rendering provider's NPI.
R	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.
CR	25	Name of Referring Physician or Facility – Enter the name of the referring or ordering practitioner if the service or item was ordered or referred by a practitioner. Referring Practitioner – a practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Practitioner – A practitioner who orders non-physician services for the Participant such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
CR	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.
NR	27	Medicare Provider ID Number – Leave blank.
R	28	Taxonomy Code - Enter the appropriate ten-digit HIPAA Provider Taxonomy Code. Refer to Companion Guide .
CR	29A	TPL Code – The patient's numeric three-digit TPL code must be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the digit TPL code. Do not include the leading alpha character. If the TPL code is not known, enter code "999." If the participant has more than one third party resource, the additional TPL is to be shown in Fields 30A – 30D. Do not report Medicare information in the TPL fields. Spendedown – The following provides examples: When the date of service is the same as the "Spendedown 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.
CR	29A	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 is the actual participant liability as shown on the HFS 2432 TPL Date is the issue date on the bottom right corner of the HFS 2432. If the HFS 2432 shows a participant liability of \$0.00, the fields should be coded as follows:

		<p>TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432.</p> <p>If the HFS 2432 shows a participant liability of greater than \$0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows:</p> <p>Claim 1 TPL Code 906 TPL Status 01 TPL Amount is the actual participant liability up to total charges TPL Date is the issue date on the bottom right corner of the HFS 2432.</p> <p>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 is the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.</p>
CR	29A	<p>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:</p> <p>Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.</p> <p>Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date is the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.</p> <p>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.</p>
CR	29B	<p>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:</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 practitioner 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</p>

		<p>entered when the practitioner is advised by the third party resource that services provided are not covered.</p> <p>04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient’s HFS 2432 shows \$0.00 liability.</p> <p>05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource is not in force</p>																		
CR	29B	<p>06 – Services not covered: TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided.</p> <p>07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed.</p> <p>10 – Deductible not met: TPL Status Code 10 is to be entered when the practitioner has been informed by the third party resource that non-payment of the service was because the deductible was not met.</p>																		
CR	29C	TPL Amount – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the “Status” field.																		
CR	29D	<p>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.</p> <table border="0"> <thead> <tr> <th>Status Code</th> <th>Date to be entered</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>02</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>03</td> <td>Third Party Adjudication Date</td> </tr> <tr> <td>04</td> <td>Date from the HFS 2432, Split Billing Transmittal</td> </tr> <tr> <td>05</td> <td>Date of Service</td> </tr> <tr> <td>06</td> <td>Date of Service</td> </tr> <tr> <td>07</td> <td>Date of Service</td> </tr> <tr> <td>10</td> <td>Third Party Adjudication Date</td> </tr> </tbody> </table>	Status Code	Date to be entered	01	Third Party Adjudication Date	02	Third Party Adjudication Date	03	Third Party Adjudication Date	04	Date from the HFS 2432, Split Billing Transmittal	05	Date of Service	06	Date of Service	07	Date of Service	10	Third Party Adjudication Date
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CR	30A	TPL Code – (See 29A above).																		
CR	30B	TPL Status – (See 29B above).																		
CR	30C	TPL Amount – (See 29C above).																		
CR	30D	TPL Date – (See 29D above).																		
R	31	<p>Provider Signature - After reading the certification statement printed on the back of the claim form, the practitioner or authorized representative must sign the completed form. The signature must be handwritten in black or blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the practitioner. The practitioner’s signature should not enter the date section of this field.</p>																		
R	32	<p>Date – The date of the practitioner’s signature is to be entered in the MMDDYY format.</p>																		

Non Institutional Provider Additional Forms

[Form HFS 1409 \(pdf\)](#), Prior Approval Request

Form HFS 1409 (pdf), Prior Approval Request, revision date (R 11-15) is to be submitted by the provider for certain specified services in order for the services to qualify for DME and

supplies; bariatric surgery, and home health reimbursement. Services and items requiring prior approval are identified in the appropriate fee schedule. For Therapy prior approval, see [Form HFS 3701T](#). R = Required; NR = Not Required; CR = Conditionally Required

Entry	Item	Explanation and Instructions
R	1	Recipient ID Number – Enter the nine-digit recipient identification number assigned to the patient for whom the service or item is requested.
R	2	Recipient Name - Enter the name of the patient for whom the service or item is requested.
R	3	Birthdate - Enter the patient's birthdate.
R	4	Provider/NPI # - Enter the provider number or NPI number as shown on the Provider Information Sheet.
R	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.
R	6	Provider Name – Enter the name of the provider who will provide the service or item.
R	7	Physician Name – Enter the name of the physician or other practitioner who signed the order recommending that the patient receive the specific item or service.
R	8	Provider Street Address – Enter the address of the provider.
R	9	Physician Street Address – Enter the address of the ordering practitioner.
R	10	Provider City, State ZIP Code – Enter the address of the provider.
R	11	Physician City, State, ZIP Code – Enter the address of the ordering practitioner.
R	12	Diagnosis Code – Enter the ICD-10-CM, diagnosis code that corresponds to the description listed in item 14 below.
CR	13	Additional Diagnosis – Enter additional ICD-10-CM, diagnosis codes, if applicable.
R	14	Diagnosis Description – Enter the written description, which corresponds with the diagnosis code listed in item 12.
CR	15	Patient Height/Weight – This field is required for durable medical equipment/supply requests and for gastric bypass procedures.
R	16	Procedure Code – Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested. or 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.
R		Description – Briefly describe the services, items or materials to be provided. For home health therapy services enter frequency, duration and service time frames.
R		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. For home therapy services enter the number of visits requested.
R		Cat. Serv – Enter the two-digit category of service (COS) corresponding to

Entry	Item	Explanation and Instructions																
		the related item/service. Valid entries are:																
		<table border="1"> <thead> <tr> <th>COS</th> <th>Item/Service</th> <th>COS</th> <th>Item/Service</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Physician</td> <td>04</td> <td>Podiatric</td> </tr> <tr> <td>41</td> <td>Medical Equipment and Prosthetic Devices</td> <td>48</td> <td>Medical Supplies</td> </tr> <tr> <td>45</td> <td>Optical Supplies</td> <td>66</td> <td>Home Health Services</td> </tr> </tbody> </table>	COS	Item/Service	COS	Item/Service	01	Physician	04	Podiatric	41	Medical Equipment and Prosthetic Devices	48	Medical Supplies	45	Optical Supplies	66	Home Health Services
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01	Physician	04	Podiatric															
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45	Optical Supplies	66	Home Health Services															
R		Prov Charge – Enter the total amount to be charged for the item or service being requested.																
NR		Approved HFS Amt – Leave blank.																
CR		Begin Date – If an item or service has already been provided, enter the date the item or service was provided. If item or service will not be provided until the prior approval is granted, leave blank.																
CR		End Date – Indicate the ending date of service, if applicable.																
R		Pur/Rent DME Provider Codes: All Other Providers F – Repair P - Purchase M – Modification R - Rental P – Purchase R - Rental																
	7-20	To be used for additional procedures. If you list more than 5 procedures another request must be submitted.																
CR	21	Additional Medical Necessity – To be used for other medical information. For optical, in addition to a narrative explanation, diagnosis and visual acuity both with and without glasses should be provided.																
NR	22	Approving Authority Signature –																
R	23	Provider Signature/Date – to be signed in ink by the individual who is to provide the service.																


Form [HFS 1977](#) (pdf) Acknowledgment of Receipt of Hysterectomy Information

Part I

Item	Instructions
Recipient Name	Must be participant's first and last name.
Recipient Identification No.	Must be the participant's nine (9) digit identification number. The number must match participant number on claim.
Physician name	Must be completed with practitioner's name and match Physician's Signature on this form.
Provider No.	Enter the practitioner's NPI.

Part II

Item	Instructions
Acknowledgement	Enter the participant's first and last name.
Recipient or Representative Signature	Recipient's Signature – Must match Recipient Name. Representative Signature – Any signature is acceptable.

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Date	Must be completed in the MMDDYY format.
Interpreter Signature	If applicable, an original signature is required.
Date	Must be completed if there is an Interpreter Signature.

Part III

Item	Instructions
Physician Signature	Must be an original signature. Stamped signatures are not acceptable.
Date	Must be completed in the MMDDYY format.

Part IV

Exception Request

Exception #1: The cause of sterility must be stated. Exception #2: The life threatening emergency situation must be indicated. Exception #3: The date of surgery must be entered. The date of the procedure must match the date of service on the claim.


If an Exception Request is completed, all items in Part I must be properly completed. The participant signature is not required. The Physician's Signature and Date are required.

Form [HFS 2189](#), Sterilization Consent Form

To facilitate processing a claim to which the attachment of Form [HFS 2189](#) (pdf) is required, all sections must be completed. The terminology regarding the sterilization should be consistent throughout the consent form.

Consent to Sterilization

Entry	Instructions
R	Physician or clinic name - Must be the name of the practitioner or clinic responsible for giving the participant the required information regarding sterilization.
R	Name of sterilization operation - Must match the sterilization listed on the claim.
R	Recipient's birth date - Must be the participant's birth date as listed on the claim.
R	Recipient's name - Must be participant's name. Must match participant's name on claim and other entries for participant name on this form.
R	Physician's name - Must be name of practitioner or clinic that performed sterilization.
R	Sterilization Method - Must match the sterilization listed on the claim.
R	Recipient's signature - Must be participant's full first and last name. Must match name on claim and be an original signature in black or blue ink. Hand-printed signature is acceptable.
R	Date consent form signed by participant - Must be the date that the participant signed the consent form. <ul style="list-style-type: none"> • Must be at least 72 hours prior to date of sterilization as listed on claim and physician statement on consent form. No Exceptions • Must be more than 30, but less than 180 days prior to date of sterilization. • If less than 30 days: <ul style="list-style-type: none"> • Practitioner must give explanation as outlined in final paragraph of consent form – giving either the participant's original expected delivery date or an explanation of the emergency abdominal surgery. • When premature delivery is checked, the original expected date must be more than 30, but less than 180 days after consent form was signed.

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<input type="radio"/>	Race and Ethnicity Designation
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Interpreter's Statement

Entry	Instructions
CR	Interpreter's statement - Must specify the language into which the sterilization information has been translated.
CR	Interpreter's signature - Must be interpreter's name and an original signature in black or blue ink. Printed signature is acceptable.
CR	Date of interpreter's statement - Must be completed if there is an interpreter's signature in MMDDYY format.

Statement of Person Obtaining Consent

Entry	Instructions
R	Name of individual - Must be the participant's name. Must match name on claim.
R	Sterilization Operation - Must match the sterilization procedure listed on the claim.
R	Signature of person obtaining consent - Must be an original signature in black or blue ink.
R	Date consent was obtained - Must be a date in MMDDYY format.
R	Facility - Must refer to the location of the practitioner or clinic obtaining the consent.
R	Facility address - Must refer to the location of the practitioner or clinic obtaining the consent.

Physician's Statement


Entry	Instructions
R	Name of individual to be sterilized - Must be the participant's name. Must match the name on the claim.
R	Date of sterilization - Must match the date of sterilization listed on claim in MMDDYY format.
R	Type of operation - Must match sterilization listed on claim.
R	Physician's signature – Must be an original signature in black or blue ink of practitioner who performed the sterilization procedure. No stamped signatures are acceptable.
R	Date - Date of practitioner's signature. Must be either the same date as the participant's consent or later and in MMDDYY format.

Form [HFS 2390](#), Abortion Payment Application

If any of the following items are not completed as outlined below, the claim and the Payment Application form will be returned to the practitioner. Entries must be typed or printed in black ink.

Participant Information

Item	Instructions
Recipient Name	Must be the participant's first and last name.
Recipient Address	Must be completed with participant's address.
Recipient's Case Identification No.	Must be completed with participant's case identification number.
Recipient's I.D.Number	Must be completed with the recipient's I.D. number. Must match the recipients I.D. number on invoice.

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Facility/Procedure Information

Item	Instructions
Date	Must be the date the service was performed in MMDDYY format.
Abortion Reason	Check the box for the appropriate reason and type of procedure performed. Must match procedure code on the claim. Mifepristone is to be checked for non-surgical abortions.

Physician Statement

Item	Instructions
Physician Performing Abortion	Enter the physician's full name.
Medicaid Provider Number	Enter the practitioner's NPI.
Street Address	Enter the practitioner's office street address.
City, State, ZIP	Enter the practitioner's office city, state and ZIP Code.
Signature of Physician Performing Abortion	Must be an original signature of the practitioner who performed the abortion. No stamped signatures are acceptable.
Date	Enter the date the practitioner signed the application in MMDDYY format.

Form [HFS 3701T](#), Therapy Prior Approval Request

Entry	Item	Item Explanation and Instructions
R	1	Recipient # – Enter the nine-digit number assigned to the patient for whom the service or item is requested.
R	2	Recipient Name – Enter the name of the patient for whom the service or item is requested.
R	3	Birth date – Enter the patient's birth date.
R	4	Provider Name and Mailing Address – Enter the provider name and address registered to the provider number provided.
R	5	Provider Number - Enter the HFS legacy provider number as it appears on the Provider Information Sheet.
R	6	Provider NPI – Enter the 10-digit National Provider Identifier of the provider that will provide the requested therapy.
R	7	Provider Telephone/Contact Name – Enter the area code/telephone number and a contact name of someone who can provide information regarding the prior approval if necessary.
R	8	Referring Physician Name – Enter the name of the practitioner who signed the order or prescription recommending that the patient receive a specific therapy.
R	9	Diagnosis Code – Enter the ICD-10 code that corresponds to the description listed in box #10.
R	10	Diagnosis Description – Enter the written description that corresponds to the diagnosis code listed in box #9.
R	11	Procedure Code – Enter the five-digit CPT code that identifies the specific therapy being requested. COS (Category of Service) – Physical Therapy – COS 11; Occupational Therapy – COS 12; Speech Therapy – COS 13

		<p>Begin Date/End Date – Enter the dates requested for therapy to begin & end.</p> <p>Frequency X Duration – Enter the actual number of visits requested. Do not use units. This number should not exceed the number of visits ordered.</p> <p>Total Quantity of Visits – Enter the actual number of visits requested. Do not use units. This number should not exceed the number of visits ordered.</p>
CR	12	Procedure Code – Enter any additional ordered therapy code.
CR	13	Procedure Code – Enter any additional ordered therapy code.
CR	14	Procedure Code – Enter any additional ordered therapy code.
		<p>The following documents should be attached to this form:</p> <ul style="list-style-type: none"> • Therapist Initial Evaluation or most current re-evaluation • Plan of Care (POC) signed and dated by the therapist. • Practitioner order/referral for the requested therapy. Must be signed and dated by the practitioner. Orders signed by APNs, PA-Cs, FNPs, or NPs are acceptable. • The evaluation visit should not be included in the quantity of visits requested. • This form does not apply to therapies requested by Home Health Agencies. • Requests for supplies and medical equipment should not be submitted on this form. • All requests for supplies and medical equipment must be made on the HFS 1409, Prior Approval Request Form <p>Initial requests (with evaluation) and renewal requests (with re-evaluation/progress note) may be faxed to 217-524-0099.</p> <p>Reviews and additional information may be faxed to 217-558-4359.</p> <p>Provider Signature/Date – To be signed and dated in ink by the individual who is to provide the requested therapy service.</p>