Audiology Services - Appendices

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Appendix E-1

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

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

- Use an original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed forms.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL LETTERS. The character pitch/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the box.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly. Correction tape is preferred.
- 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. Do not use staples.

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

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

Required = Entry always required.

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

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

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

Completion	Item	Explanation and Instructions
Required	**1.**	**Provider Name** – Enter the provider's first and last name as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** – Enter the provider's NPI.
Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Not Required	4.	Role – Leave blank.
Not Required	5.	Emer – Leave blank.
Not Required	6.	Prior Approval – Leave blank.
Optional	**7.**	**Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider errors. If address is not entered, the Department will not attempt corrections.
Conditionally Required	**8.**	**Facility & City Where Service Rendered** – This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office) or 12 (home).
Optional	**9.**	**Provider City State ZIP** – Enter city, state and ZIP code of provider.
Required	**10.**	**Referring Practitioner Name** – Enter the name of the Otologist, Otolaryngologist, Audiologist or primary physician who referred the patient for audiology services.
Required	**11.**	**Recipient Name** – Enter the patient'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.
Required	**12.**	**Recipient Number** – Enter the nine-digit number assigned to the individual. Use no punctuation or spaces. Do **not** use the Case Identification Number.

Completion	Item	Explanation and Instructions
Optional	**13.**	**Birth Date** – Enter the month, day and year of birth of the patient. Use the MMDDYYYY format. If the birth date is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birth date is not entered, the Department will not attempt corrections.
Not Required	14.	H Kids – Leave Blank.
Not Required	15.	Fam Plan – Leave Blank.
Not Required	16.	St/Ab – Leave Blank
Required	**17.**	**Primary Diagnosis Description** – Enter the primary diagnosis description applicable to the condition primarily responsible for the patient's treatment.
Required	**18.**	**Primary Diag. Code** – Enter the specific ICD-9-CM code for dates of service prior to 10/01/2015, or the specific ICD-10 code for dates of service on or after 10/01/2015, without the decimal for the primary diagnosis described in Item 17.
Required	**19.**	**Taxonomy** – Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300.
Optional	**20.**	**Provider Reference** – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-2, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. – Leave blank.
Not Required	22.	Secondary Diag Code – Leave blank.
	23.	**Service Sections** – Complete one Service Section for each item or service provided to the patient.
Required		**Procedure Description/Drug Name, Form and Strength or Size** – Enter the description of the service provided or item dispensed.
Required		**Proc. Code/NDC** – Enter the appropriate CPT.
Conditionally Required		**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.
Required		**Date of Service** – Enter the date the service was provided. Use MMDDYY format.
Required		**Cat. Serv.** – Enter the appropriate two-digit category of service code. 14 - Audiology Services
Conditionally Required		**Delete** – When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only the "X" will be recognized as a valid character; all others will be ignored.

Completion	Item	Explanation and Instructions
Required	**23. (cont.)**	**Place of Serv.** – Enter the two-digit Place of Service code from the following list: 11 - Office 12 - Home 13 - Assisted Living Facility 14 - Group Home 19 - Off-Campus Outpatient Hospital (effective 01/01/2016) 21 - Inpatient hospital 22 - On-Campus Outpatient hospital 31 - Skilled Nursing Facility 32 - Nursing Facility 33 - Custodial Care Facility
Conditionally Required		**Units/Quantity** – Enter the appropriate number of units for the service.
Not Required		Modifying Units – Leave Blank.
Conditionally Required		**TPL Code** – If payment was received from a third party resource, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in Sections 25-27. Do not attach a copy of the TPL Explanation of Benefits (EOB). Do not report Medicare information in the TPL fields. Refer to Appendix E-1a for information regarding Medicare crossovers. For Medicare denied services with an additional TPL resource involved, please report the following: • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOMB. • Attach a copy of the Medicare EOMB. • Do not report the Medicare information in the TPL field. **Spenddown** – Refer to the Chapter 100 Handbook for a full explanation of the spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form HFS 2432 shows a participant liability greater than $0.00 the Service Section should be coded as follows: TPL Code 906 TPL Status 01

Completion	Item	Explanation and Instructions
Conditionally Required	**23. (cont.)**	TPL Amount The actual participant liability as shown on the HFS 2432 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If 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: The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should coded as follows: Claim 1 TPL Code: 906 TPL Status: 01 TPL Amount: The actual participant liability up to total charges TPL Date: The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code: 906 TPL Status: 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining participant liability from claim 1 is $0.00. TPL Amount: If status code 01 was used in claim 2 status field, enter amount of remaining participant liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date: The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code: 906 TPL Status: 04 TPL Amount: 000 TPL Date: The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required	**23. (cont.)**	Claim 2 TPL Code: 906 TPL Status: 04 TPL Amount: 000 TPL Date: The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions. **Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – Spenddown met:** TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services Not Covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 – Deductible Not Met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Explanation and Instructions
Conditionally Required	**23. (cont.)**	**TPL Amount** – Enter the amount of payment received from the patient's third party for the service. 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. **TPL Date** – A TPL date is required when any status code is shown. 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 **Provider Charge** – Enter the total charge for the service, not deducting any TPL or co pays.
Not Required	24.	Optical Materials Only – Leave blank.

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.

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

Completion	Item	Explanation and Instructions
Conditionally Required	**25A.**	**TPL Code** – Enter the appropriate TPL Code referencing the source of payment. If no TPL Code, enter 999 and enter the name of the payment source in section 35.
Conditionally Required	**25B.**	**Status** – Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.
Conditionally Required	**25C.**	**TPL Amount** – Enter the amount of payment received from the third party resource.
Conditionally Required	**25D.**	**TPL Date** – Enter the date the claim was adjudicated by the third party resource. (See the TPL Date field in Item 23 above for correct coding of this field.)
Conditionally Required	**26.**	**Sect. #** – Enter (See 25 above).
Conditionally Required	**26A.**	**TPL Code** – (See 25A above.)
Conditionally Required	**26B.**	**Status** – (See 25B above).
Conditionally Required	**26C.**	**TPL Amount** – (See 25C above).
Conditionally Required	**26D.**	**TPL Date** – (See 25D above).
Conditionally Required	**27.**	**Sect.** – (See 25 above).
Conditionally Required	**27A.**	**TPL Code** – (See 25A above).
Conditionally Required	**27B.**	**Status** – (See 25B above).
Conditionally Required	**27C.**	**TPL Amount** – (See 25C above).
Conditionally Required	**27D.**	**TPL Date** – (See 25D above).

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.

Completion	Item	Explanation and Instructions
Required	**28.**	**Tot Charge** – Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
Required	**29.**	**Tot Deductions** – Enter the sum of all payments submitted in the TPL Amount field in the Service Sections 1 through 6. If no payment was received, enter zeroes (0 00). Do not deduct Department co-payments.
Required	**30.**	**Net Charge** – Enter the difference between Total Charge and Total Deductions.
Required	**31.**	**# Sects** – Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections that were deleted because of errors.
Not Required	32.	Original DCN – Leave blank.
Not Required	33.	Sect. – Leave blank.
Not Required	34.	Bill type – Leave blank.
Conditionally Required	**35.**	**Uncoded TPL Name** – Enter the name of the third party resource. The name must be entered if TPL code 999 is used.
Required	**36-37.**	**Provider Certification, Signature and Date** – After reading the certification statement, the provider or their authorized biller must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format.

Mailing Instructions

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider. Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the Department.

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

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

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

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

Appendix E-2

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

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

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

Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797.

A sample of the HFS 3797 (pdf) may be found on the Department's website. Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form.**

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

Required = Entry always required.

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

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

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

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

Completion	Item	Explanation and Instructions
Required	**10C.**	**T.O.S. (Type of Service)** – Enter TOS as submitted to Medicare.
Required	**10D.**	**Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB).
Required	**10E.**	**Procedure Code** – Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
Required	**10F.**	**Amount Allowed** – Enter the amount allowed by Medicare for the service(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10G.**	**Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Enter the amount the provider was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Conditionally Required	**11.**	**For NDC Use Only** – Required when billing NDC codes for pharmacy/physician claims.
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	13A.	Origin of Service – Leave blank.
Not Required	13B.	Modifier – Leave blank.
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.
Not Required	15A.	Origin of Service – Leave blank.
Not Required	15B.	Modifier – Leave blank.
Not Required	16A.	Destination of Service – Leave blank.

Completion	Item	Explanation and Instructions
Not Required	16B.	Modifier – Leave blank.
Optional	**17.**	**ICN #** – Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on Form HFS 194-M-2, Remittance Advice, returned to the provider.
Conditionally Required	**18.**	**Diagnosis or Nature of Injury or Illness** – Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-10 code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the specific ICD-9-CM code for dates of service prior to 10/01/2015, or the specific ICD-10 code for dates of service on or after 10/01/2015, without the decimal, for the primary diagnosis described in Item 18.
Optional	**18B.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter the specific ICD-9-CM code for dates of service prior to 10/01/2015, or the specific ICD-10 code for dates of service on or after 10/01/2015, without the decimal, for any applicable secondary diagnosis.
Required	**19.**	**Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.
Conditionally Required	**20.**	**Name and Address of Facility Where Services Rendered** – This entry is required when Place of Service (10B) is other than provider's office or participant's home. Enter the facility name and address where the service(s) was 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."
Required	**21.**	**Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to participants for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box.

Completion	Item	Explanation and Instructions
Required	**22.**	**Physician/Supplier Name, Address, City, State, and ZIP Code** – Enter the physician/supplier name exactly as it appears on the Provider Information Sheet in the "Provider Key."
Required	**23.**	**HFS Provider Number** – Enter the rendering Provider's NPI.
Required	**24.**	**Payee Code** – Enter the single-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Conditionally Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the referring or ordering practitioner if the service or item was ordered or referred by a practitioner. Referring Practitioner – A practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Practitioner – A practitioner who orders non-physician services for the Participant such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a physician's order or referral must include the ordering/referring physician's NPI number.
Not Required	27.	Medicare Provider ID Number – Leave blank.

Completion	Item	Explanation and Description
Required	**28.**	**Taxonomy Code** – Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.
Conditionally Required	**29A.**	**TPL Code** – If payment was received from a third party resource, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in Fields 30A – 30D. **Do not report Medicare information in the TPL fields.** **Spenddown** – Refer to Chapter 100 Handbook for a full explanation of the spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form HFS 2432 shows a participant liability greater than $0.00 the Service Section should be coded as follows: 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. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00, the Service Section should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

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

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

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

MAILING INSTRUCTIONS

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

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

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

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

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

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

Forms Requisition - Billing forms may be requested on our website or by submitting a HFS 1517 as explained in the Chapter 100 Handbook for Providers of Medical Services.

Appendix E-3

Technical Guidelines For Paper Claim Preparation
Form HFS 2210, Medical Equipment/Supplies Invoice

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

- Use an original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed forms.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL LETTERS. The character pitch/font must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the box.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly. Correction tape is preferred.
- 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 photo-copying 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. Please do not use staples.

A sample of the HFS 2210 (pdf) may be found on the Department's website. Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

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

Required = Entry always required.

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

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

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

Completion	Item	Explanation and Instructions
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** – Enter the National Provider Identifier (NPI) number.
Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**4.**	**Billing Date** – Enter the date the claim form was prepared.
Optional	**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.
Optional	**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 an address is not entered, the Department will not attempt corrections.
Optional	**7.**	**Provider City, State, ZIP** – Enter city, state and ZIP code of provider. See Item 6 above.

Completion	Item	Explanation and Instructions
	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, or to bill for multiple patients. If attachments such as split bill forms are required to be mailed with the claim, bill for only one participant per claim. Also, if the purchase/rent code is "3" for repair, bill for only one participant per claim. At least one service section must be completed, as follows:
Required		**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.
Required		**Recipient No.** – Enter the nine-digit number assigned to the individual. Do not use the Case Identification Number.
Optional		**Birth date** – Enter the month, day and year of birth of the patient. Use the MMDDYY format.
Conditionally Required		**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
Not Required		Health Kids – Leave blank.
Not Required		Cr. Child – Leave blank.
Conditionally Required		**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.

Completion	Item	Explanation and Instructions
Required	**8. (cont.)**	**Primary Diagnosis** – Enter the diagnosis description from the ICD-9-CM manual for dates of service prior to 10/01/2015, or from the ICD-10 manual for dates of service on or after 10/01/2015 that describes the condition primarily responsible for the patient's need for the items. When necessary, abbreviate.
Conditionally Required		**Prefix** – When the ICD-9-CM Diagnosis Code has an alphabetic prefix of E or V, or when the ICD-10 Diagnosis Code has an alphabetic prefix of V, W, X, Y or Z, enter it here.
Required		**Diag. Code** – Enter the primary diagnosis code exactly as it appears in the ICD-9-CM manual for dates of service prior to 10/01/2015, or as it appears in the ICD-10 manual for dates of service on or after 10/01/2015. All characters to the left of the decimal point should be entered to the left of the dividing line. All characters to the right of the decimal point should be entered to the right of the dividing line. **Do not enter the decimal point**.
Required		**Ordering Practitioner Name (First, Last)** – Enter the name of the practitioner who determined the need for the item dispensed.
Required		**Ordering Practitioner Number** – Enter the ordering practitioner's NPI.
Not Required		Order Number – Leave blank.
Conditionally Required		**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. If this field is completed, it may assist Department staff to resolve prior approval problems that cause the claim to be rejected.
Required		**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 reimbursement listings on the Department's website.
Required		**Item** – Enter the appropriate five-digit HCPCS.

Completion	Item	Explanation and Instructions
Required	**8. (cont.)**	**Purchase/Rent** – Enter one purchase/rental code as follows: For COS 41, Medical Equipment/Prosthetic Devices 1 = Purchase 2 = Rental 3 = Repair 5 = Loaner For COS 48, Medical Supplies 1 = Purchase
Required		**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). If the purchase/rental code is "2", the quantity must be "1". Exceptions are identified in the reimbursement listings on the Department's website.
Required		**Date of Service** – Enter the date the service or item was provided to the patient. Use MMDDYY format.
Conditionally Required		**TPL Code** – If payment was received from a third party resource, enter the appropriate TPL Code listed in Chapter 100, General Appendix 9. If the participant has more than one third party resource, the additional TPL is to be shown in Section 9. **Do not attach a copy of the TPL Explanation of Benefits (EOB).** **Do not report Medicare information in the TPL fields. Refer to Appendix E-1a for information regarding Medicare crossovers.** For Medicare denied services with an additional TPL resource involved, please report the following: • Enter other TPL information in the TPL field. • Do not attach a copy of the other TPL EOMB. • Attach a copy of the Medicare EOMB. • Do not report the Medicare information in the TPL field. **Spenddown** – Refer to Chapter 100, Topic 113 for a full explanation of the spenddown policy.

Completion	Item	Explanation and Instructions
Conditionally Required	**8. (cont.)**	The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form HFS 2432 shows a participant liability greater than $0.00 the Service Section should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount The actual participant liability as shown on the HFS 2432 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If 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 The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.
Conditionally Required		If the HFS 2432 shows a participant liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should BE coded as follows: Claim 1 TPL Code 906 TPL Status 01 TPL Amount The actual participant liability up to total charges TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date The issue date on the bottom right corner of

		the HFS 2432. This is in MMDDYY format.
Completion	**Item**	**Explanation and Instructions**
Conditionally Required	**8. (cont.)**	If the HFS 2432 shows a participant liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions. **Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – Spenddown met:** TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the

<table>
<tr><th>Completion</th><th>Item</th><th>Explanation and Instructions</th></tr>
<tr><td>Conditionally Required</td><td>8. (cont.)</td><td>third party resource is not in force.
06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
10 - Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

TPL Amount – Enter the amount of payment received from the patient’s third party for the service. 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.

TPL Date – A TPL date is required when any status code is shown. 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, Split Bill Transmittal
05 Date of Service
06 Date of Service
07 Date of Service</td></tr>
<tr><td>Required</td><td></td><td>Provider Charge – Enter the total charge for the Service Section, not deducting any third party liability.</td></tr>
<tr><td>Conditionally Required</td><td></td><td>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.</td></tr>
</table>

Completion	Item	Explanation and Instructions
Conditionally Required	**8. (cont.)**	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. The Repeat box may not be used following a Service Section that has been deleted.
Conditionally Required	**9.**	**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.
Conditionally Required	**12.**	**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.
Conditionally Required	**13A.**	**TPL Code** – Refer to the instructions for **TPL Code** above.
Conditionally Required	**13B.**	**Status** – Refer to the instructions for **Status** above.
Conditionally Required	**13C.**	**TPL Amount** - Refer to the instructions for **TPL Amount** above.
Conditionally Required	**13D.**	**TPL Date** – Refer to the instructions for **TPL Date** above.
Required	**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.
Required	**15.**	**Total Charge** – Enter the sum of all charges submitted on this claim in Service Sections 1-5.
Conditionally Required	**16.**	**Total Deductions** – Enter the sum of all payments received from other sources. If no payment was received, leave blank.
Required	**17.**	**Net Charge** – Enter the difference between Total Charge and Total Deductions.
Required		**Provider Certification, Signature and Date** – After reading

Completion	Item	Explanation and Instructions
Required	**17. (cont)**	The certification statement, the provider must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. The signature date is to be entered.

MAILING INSTRUCTIONS

The Medical Equipment/Supplies Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip should be detached from the sides of continuous feed forms. The copy of the claim is to be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 2247, Medical Equipment/Supplies Envelope, provided by the Department.

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

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

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

Forms Requisition- Billing forms may be requested on our website or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix E-4

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

Form HFS 1409 (pdf), Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Instructions for Completion

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

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

Required = Entry always required.

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

Not Required = Fields not applicable; leave blank.

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

Completion	Item	Explanation and Instructions
Required	**5.**	**Provider Telephone #** – Enter the telephone number of the provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**6.**	**Provider Name** – Enter the name of the provider who will provide the service or item.
Required	**7.**	**Physician Name** – Enter the name of the practitioner who signed the order or prescription recommending that the patient receive the specific item or service.
Required	**8.**	**Provider Street Address** – Enter the address of the provider.
Required	**9.**	**Physician Street Address** – Enter the address of the ordering practitioner.
Required	**10.**	**Provider City, State, ZIP Code** – Enter the address of the provider.
Required	**11.**	**Physician City, State, ZIP Code** – Enter the address of the ordering practitioner.
Required	**12.**	**Diagnosis Code** – Enter the ICD-9-CM diagnosis code for dates of service prior to 10/01/2015, or the ICD-10 diagnosis code for dates of service on or after 10/01/2015, that corresponds to the description listed in Item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis** – Enter the additional ICD-9-CM diagnosis code(s) for dates of service prior to 10/01/2015, or the ICD-10 diagnosis code(s) for dates of service on or after 10/01/2015, if applicable.
Required	**14.**	**Diagnosis Description** – Enter the written description, which corresponds with the diagnosis code listed in Item 12.
Not Required	15.	Patient Height/Weight – Leave blank.

Completion	Item	Instructions and Completion
Required	**16.**	**Procedure Code** – Enter the five-digit HCPCS code that identifies the specific item/service being requested. For audiology – if a quantity of two is requested (for instance, right and left), list the specific HCPCS code for the first, then 99199 for the second. **Description** – Briefly describe the services or items or materials to be provided. **Qty** – Enter the number of items to be dispensed within the timeframe covered by the prior approval request or enter the number of times the service is to be performed. **Cat. Serv** – Enter the two-digit category of service (COS) code corresponding to the related item/service. Valid entries are: 41 - Medical Equipment/Prosthetic Devices, Hearing Aids 48 - Medical Supplies **Prov Charge** – Enter the total amount to be charged for the item being requested. **Approved HFS Amt** – Leave Blank. **Begin Date** – If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval is granted, leave blank. **End Date** – Indicate the ending date of service, if applicable. **Pur/Rent** – For medical equipment/supplies enter P for purchase. Mod – Leave blank.
Conditionally Required	**17-20**	To be used for additional procedures. If more than five procedures are listed, another request must be made.
Required	**21.**	**Additional Medical Necessity** – To be used for other medical information.
Not Required	22.	Approving Authority Signature
Required	**23.**	**Provider Signature/Date** – To be signed in ink by the individual who is to provide the service.

Mailing Instructions

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

The HFS 1409 may be mailed in a pre-addressed mailing envelope, Form HFS 2300, provided by the Department.

The top, signed copy of the request is to be mailed to:

Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, IL 62794-9124

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

Forms Requisition:

The HFS 1409 (pdf) form is available in a PDF-fillable format on the HFS Medical Programs Forms webpage. This form and HFS 2300 envelope may also be requested on the HFS Medical Forms Request webpage or by submitting a 1517, as explained in Chapter 100 Handbook, General Appendix 10.

Fax Instructions

The signed copy of the HFS 1409 may be faxed Monday through Friday, 8:30 AM – 5:00 PM, except holidays, to 217-524-0099.

Appendix E-5
Explanation of Information on Provider Information Sheet

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

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

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix E-5a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI shown in Field 8.
Provider Name and Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification. **Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Individual Practice 02 = Partnership 03 = Corporation 04 = Group Practice

Field	Explanation
Enrollment Specifics	**Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive Disregard the term NOCST if it appears in this item. Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in 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. **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Exception Requested by Audits C = Citation to Discover Assets G = Garnishment T = Tax Levy If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank. **AGR** (Agreement) indicates whether the provider has agreed to the Terms & Conditions in IMPACT. If the value of the field is yes, the provider is eligible to submit claims electronically.
Certification/ License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.

Field	Explanation
Categories of Service	This area identifies the types of services, procedure(s) and current rate a provider is enrolled to provide. **Procedure Code** Identifies and defines the specific procedure(s) codes the provider is enrolled to perform. Immediately following the procedure description is the**date** the provider has been approved to render services and the reimbursable **rate** approved by the Department for each listed service rendered by the provider. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are: 014 - Audiology Services. 041 - Medical Equipment/ Prosthetic Devices. 048 - Medical Supplies. This entry is followed by the date that the provider was approved to render audiology services.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes. Therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
NPI	The National Provider Identification Number contained in the Department's provider database.

APPENDIX E-5a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 11/02/15
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 11/02/15
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
3333333330001

PROVIDER NAME AND ADDRESS
DOE, DORIS
1441 MY STREET
ANYTOWN, IL 62222-2222

PROVIDER GENDER:
COUNTY 058-LASALLE
TELEPHONE NUMBER (888)123-4567

PROVIDER TYPE: 025 – AUDIOLOGIST
ORGANIZATION TYPE: 01 – INDIVIDUAL PRACT
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 12/27/14 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: NO BILL: NONE

CERTIFIC/LICENSE NUM –040011111 ENDING 03/31/17

LAST TRANSACTION COR AS OF 12/18/15 SS #:331313131
CLIA#:

D.E.A.#:
RE-ENROLLMENT INDICATOR: N DATE: 12/27/14
HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	BEG DATE	SPECIALTY
005	CHIROPRACTIC SERVICES	06/15/17				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	DR DOE DORIS	1441 MY STREET	ANYTOWN	IL	62222	331313131-60077-01		12/27/14
	DBA: AUDIOLOGY SERVICES INC			VENDOR ID: 30				
	MEDICARE/PIN:							

*** NPI NUMBERS REGISTERED FOR THIS PROVIDER ARE:
XXXXXXXXX

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

Appendix E-6
Internet Quick Reference Guide

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

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