Laboratory Services - Appendices

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Appendix L-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2211, Laboratory/Portable X-Ray Invoice

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

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use black or dark blue ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border, as a result of photocopying with the copier cover open, cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

A sample of the HFS 2211 may be found on the Department's website. Instructions for completion of this claim 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 claiming errors by the Department.

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

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

Completion	Item	Item Explanation and Instructions
Required	**1.**	**Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** – Enter the National Provider Identifier (NPI) number.
Conditionally 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. 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.
Not Required	4.	Group – Leave blank.
Not Required	5.	Role – Leave blank.
Not Required	6.	Acc/Inj – Leave blank.
Optional	**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.

Completion	Item	Item Explanation and Instructions
Optional	**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.
Conditionally Required	**9.**	**Facility & City Where Service Rendered** – This entry is required when Place of Service Code is other than J (laboratory).
Not Required	10.	Prior Approval – Leave blank.
Optional	**11.**	**Provider City, State, ZIP** – Enter city, state and ZIP code of provider. See Item 8 above.
Required	**12.**	**Referring Practitioner Name** – Name of practitioner ordering test.
Required	**13.**	**Ref Prac No** – Enter the referring practitioner's National Provider Identifier (NPI) number.
Required	**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.
Required	**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.
Optional	**16.**	**Birth date** – Enter the month, day and year of birth of the patient. Use the MMDDYY format. If the birth date is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birth date is not entered, the Department will not attempt corrections.
Not Required	17.	Healthy Kids – Leave blank.
Not Required	18.	Fam Plan – Leave blank.

Completion	Item	Item Explanation and Instructions
Not Required	19.	Cr Child – Leave blank.
Not Required	20.	St/Ab – Leave blank.
Required	**21.**	**Billing Date** – Enter the date the invoice was prepared. Use MMDDYY format.
Required	**22.**	**Primary Diagnosis Description** – Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.
Not Required	23.	Prefix
Required	**24.**	**Diag Code** – Effective with dates of service on and after October 1, 2015, enter the primary diagnosis code exactly as it appears in the ICD-10 manual. **This field will contain both the alpha and numeric characters of the diagnosis code.** Do not enter the decimal point.
Not Required	25.	Secondary Diagnosis – Leave blank.
Not Required	26.	Prefix – Leave blank.
Not Required	27.	Diag. Code – Leave blank.
	28.	**Service Sections** – Complete one service section for each item or service provided to the patient.
Required		**Procedure Description** – Enter the appropriate description of the service provided.
Required		**Proc Code** – Enter the appropriate five-digit procedure code as specified in this handbook.
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	Item Explanation and Instructions
Required		**Date of Service** – Enter the date the service was performed. Use MMDDYY format.
Required		**Cat Serv** – Enter 43 to identify laboratory services as the category of service.
Required		**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
Conditionally Required		**TPL Code** – The patient's TPL code is to be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the three-digit TPL code. **Spenddown** – Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) 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: 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 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. This is in MMDDYY format.

Completion	Item	Item Explanation and Instructions
Conditionally Required		**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. 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 the patient informs the provider that the third party resource identified is not in force. **06 - Services not covered**: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 - Third Party Adjudication Pending**: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 - Deductible not met**: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Item Explanation and Instructions
Conditionally Required		**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.
Conditionally Required		**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
Required		**Provider Charge** – Enter the total charge for the service, not deducting any payment from the third party resource.
Conditionally Required		**Repeat** – Place X in box if the same service is performed on an additional date of service.
Conditionally Required	**29.**	**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:

Completion	Item	Item Explanation and Instructions
Conditionally Required	**30.**	**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.
Conditionally Required		**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.
Conditionally Required		**Status** – Enter the appropriate TPL Status code. See Item 28 in this Appendix for correct coding of this field.
Conditionally Required		**TPL Amount** – Enter the amount of payment received from the third party resource.
Conditionally Required		**Adjudication Date** – Enter the date the claim was adjudicated by the third party resource. See Item 28 in this Appendix for correct coding of this field.
Conditionally Required		**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. They are located at the bottom right of the form in Item 30.
Required		**Total Charge** – Enter the sum of all charges submitted on the invoice in service sections 1 through 7.
Required		**Total Deductions** – Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).
Required		**Net Charge** – Enter the difference between Total Charge and Total Deductions fields.

Completion	Item	Item Explanation and Instructions
Required	**31.**	**# 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.
Not Required	32.	Original DCN – Leave blank.
Not Required	33.	Original Voucher Number – Leave blank.
Required		**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.

Mailing Instructions

The HFS 2211 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 2245 (Laboratory/Portable X-Ray 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 as explained in Chapter 100.

Appendix L-2

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

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

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand-keyed, which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use black or dark blue ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border, as a result of photocopying with the copier cover open, cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

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

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

Required = Entry always required.

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

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

Completion	Item	Item Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the box labeled 25 – Lab/Portable X-Ray.
Required	**1.**	**Recipient's Name** – Enter the participant's name (first, middle, last).
Required	**2.**	**Recipient's Birth date** – Enter the month, day and year of birth. Use the MMDDYY format.
Required	**3.**	**Recipient's Sex** – Enter a capital "X" in the appropriate box.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**4.** **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.
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.
Required	**10C.**	**T.O.S. (Type of Service)** – Enter the number "5".

Completion	Item	Item Explanation and Instructions
Required	**10D.**	**Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001.
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).
Not Required	11.	For NDC Use Only – Leave blank.
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	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 patient's treatments. A written description is not required if a valid ICD-9-CM, or 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 October 1, 2015, or the specific ICD-10 code for dates of service on and after October 1, 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 a specific ICD-9-CM code for dates of service prior to October 1, 2015, or the specific ICD-10 code for dates of service on and after October 1, 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 furnished. When the name and address of the facility where the services were furnished is the same as the biller's name and address as submitted in Field 22, enter the word, "Same."
Required	**21.**	**Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to participants, for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box, if accepting assignment.

Completion	Item	Item Explanation and Instructions
Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code** – Enter the practitioner/supplier name exactly as it appears on the Provider Information Sheet under "Provider Key."
Required	**23.**	**HFS Provider Number** – Enter the Provider's NPI.
Required	**24.**	**Payee Code** – Enter the single-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Conditionally Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the referring or ordering practitioner if the service or item was ordered or referred by a practitioner. Referring Physician – a practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Physician – A practitioner who orders non-practitioner services for the participant such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a practitioner's order or referral must include the ordering/referring practitioner's NPI.
Not Required	27.	Medicare Provider ID Number
Required	**28.**	**Taxonomy Code** – Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.
Conditionally Required	**29A.**	**TPL Code** – The patient's TPL code is to be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the three-digit TPL code. If the TPL code is not known, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Field 30. **Do not report Medicare information in the TPL fields.**

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29A. (cont.)**	**Spenddown** – Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount The actual participant liability as shown on the HFS 2432 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29B.**	**TPL Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
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	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. **Status Code** — **Date to be entered** 01 — Third Party Adjudication Date 02 — Third Party Adjudication Date 03 — Third Party Adjudication Date 04 — Date from the HFS 2432 05 — Date of Service 06 — Date of Service 07 — Date of Service 10 — Third Party Adjudication Date
Conditionally Required	**30A.**	**TPL Code** – (See 29A above).
Conditionally Required	**30B.**	**TPL Status** – (See 29B above).
Conditionally Required	**30C.**	**TPL Amount** – (See 29C above).
Conditionally Required	**30D.**	**TPL Date** – (See 29D above).
Required	**31.**	**Provider Signature** – After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned invoices will be rejected. The provider's signature should not enter the date section of this field.
Required	**32.**	**Date** – The date of the provider's signature is to be entered in the MMDDYY format.

Mailing Instructions

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

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

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

Do not bend or fold claims prior to submission.

Forms Requisition – Billing forms may be requested on our website or by submitting a HFS 1517 as explained in Chapter 100.

Appendix L-3

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 follows as Appendix L-3a.

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.

Field	Explanation
	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 **Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive Disregard the term NOCOST if it appears in this item. Immediately following the enrollment status indicator are the **Begin** date, indicating when the provider was most recently enrolled in Department's Medical Programs; and the **End** date, indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "Active" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative, indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = 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 and conditions in IMPACT. If the value of the field is Yes, the provider is authorized to submit claims electronically.

Field	Explanation
Certification/ License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date, indicating when the license will expire.
S.S.#	This is the provider's Social Security or FEIN number.
Specialty and Categories of Service	This area identifies special licensure information, and the types of services 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. The possible codes are: 043 = Clinical Laboratory Services Each entry is followed by the date that the provider was approved to render services for each category listed.
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 cross-over Medicare billable services. The PIN is the number assigned by Medicare to a provider within a group practice, if applicable.
NPI	The National Provider Identification Number contained in the Department's database.

Appendix L-3a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 12/05/15
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 12/05/15
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
436011111111

PROVIDER NAME AND ADDRESS

PROVIDER GENDER:
COUNTY 058-LASALLE
TELEPHONE NUMBER

D.E.A.#:
RE-ENRL IND: N DATE: 11/15/99

PROVIDER TYPE: 061 – LABORATORY
ORGANIZATION TYPE: 03 – CORPORATION
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/15/99 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 000011111 ENDING 03/31/16
UPIN#:
LAST TRANSACTION ADD AS OF 04/21/14 S.S.#:331313131
CLIA#:

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

COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	BEG DATE	TERMINATION REASON
043	CLINICAL LABORATORY SERVICES	11/15/99				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ABC LABORATORIES	1421 MY STREET	ANYTOWN	IL	62000	001010101-62000-01		11/15/99
	DBA:							
	MEDICARE/PIN: 999999/							

VENDOR ID: 01

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

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

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

Appendix L-4
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
Dental Program
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
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)