Appendix U-1
Technical Guidelines for Paper Claim Preparation
Form HFS 1443, 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 original department issued claim form.
- 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, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- 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 in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- 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 invoices or fasten attachment with staples.

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 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.

Completion	Item	Explanations 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 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. 1=Local Education Agency (as payee) **Always enter 1**
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.
Not Required	10.	Referring Practitioner Name– Leave blank.
Required	11.	**Recipient Name**– Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. 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 as shown on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Optional	13.	**Birth Date**– Enter the month, day and year of birth of the patient as shown on the Medical Programs card. Use the MMDDYYYY format. If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name or number errors. If the birth date is not entered, the department will not attempt corrections.

Completion	Item	Explanations and Instructions
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 that describes the condition primarily responsible to the patient's treatment.
Required	18.	**Primary Diag. Code-** Enter the specific ICD-9-CM code or implementation of ICD-10, 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, Appendix 5.
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 194-M-1, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. - Leave blank.
Optional	22.	**Secondary Diag Code-** A secondary diagnosis code may be entered when applicable.
	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.
Required		**Proc. Code/NDC-** Enter the appropriate CPT, HCPCS or NDC.
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. Refer to Appendix U-2.
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.
Required		**Place of Serv.**– Enter the two-digit Place of Service code from the following list: 03- School 11- Office 12- Home
Conditionally Required		**Units/Quantity-** Refer to Appendix U-2 for appropriate units to bill for service provided.
Not Required		Modifying Units- Leave blank
Not Required		**TPL Code**- Leave blank
Not Required		**Status** – Leave blank
Not Required		**TPL Amount** – Leave blank
Not Required		**TPL Date** – Leave blank
Required		**Provider Charge-** Enter the total charge for the service.
Not Required	24.	Optical Materials Only- Leave blank.

Completion	Item	Explanations and Instructions
Not Required	**25A.**	**TPL Code** – Leave blank.
Not Required	**25B.**	**Status-** Leave blank.
Not Required	**25C.**	**TPL Amount** – Leave blank.
Not Required	**25D.**	**TPL Date-** Leave blank.
Not Required	**26.**	**Sect. #-** Leave blank.
Not Required	**26A.**	**TPL Code-** Leave blank.
Not Required	**26B.**	**Status-** Leave blank.
Not Required	**26C.**	**TPL Amount-** Leave blank.
Not Required	**26D.**	**TPL Date-** Leave blank.
Not Required	**27.**	**Sect.** Leave blank.
Not Required	**27A.**	**TPL Code-** Leave blank.
Not Required	**27B.**	**Status-** Leave blank.
Not Required	**27C.**	**TPL Amount-** Leave blank.
Not Required	**27D.**	**TPL Date-** Leave blank.
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.		
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.
Not Required	**35.**	**Uncoded TPL Name-** Leave blank.
Required	**36-37**	**Provider Certification, Signature and Date-** After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black 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 EOB or split bill transmittals (HFS 2432) 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 an HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix U-2

Procedure Codes Billable by Local Education Agencies

Audiology Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category Of Service
V5299	Audiology	14

Developmental Assessments- Billed with a unit of 1 for each assessment with a maximum billable quantity of 1 unit each for 99173 and 92551, a maximum billable quantity of 8 units for 96110, and a maximum billable quantity of 7 units for 96111		
Procedure Code	Description	Category Of Service
99173	Vision screen	30
92551	Hearing screen	30
96110	Ages & Stages Questionnaires (ASQ)	30
96110	Ages & Stages Questionnaires Social Emotional (ASQ:SE)	30
96110	Battelle Developmental Screener	30
96110	Bayley Infant Neurodevelopment Screener	30
96110	Brief Infant Toddler Social and Emotional Assessment (BITSEA)	30
96110	Brigance Early Preschool	30
96110	Chicago Early Developmental	30
96110	Screening Inventory	30
96110	Denver DST/Denver II	30
96110	Developmental Profile II	30
96110	Dial-R Developmental Assessment	30
96110	Dial - 3	30
96110	Early Language Milestone Scales Screen	30
96110	Early Screening Inventory	30
96110	Early Screening Profiles	30
96110	Infant-Toddler Symptom Checklist	30
96110	Minneapolis Preschool Screening Instrument	30
96110	Modified Checklist for Autism in Toddlers M-CHAT	30
96110	Parents' Evaluation of Developmental Status (PEDS)	30
96110	Parents' Evaluation of Developmental Status -- Developmental Milestones (PEDS: DM)	30
96110	Parents' Observations of Infants and Toddlers (POINT)	30
96110	Project Memphis DST	30
96110	Revised Developmental Screening Inventory	30
96110	Revised Parent Developmental Questionnaire	30
96110	Temperament and Atypical Behavior Scale (TABS) Screener	30
96111	Battelle Developmental Inventory	30
96111	Bayley Scales of Infant Development	30

Procedure Code	Description	Category Of Service
96111	Child Behavior Checklist 2-3 and Caregiver-Teacher Report Form, Ages 2-5	30
96111	Child Development Inventory	30
96111	Conner's Rating Scales	30
96111	Early Coping Inventory	30
96111	Erhardt Development Prehension Assessment	30
96111	Hawaii Early Learning Profile	30
96111	Infant-Toddler Developmental Assessment	30
96111	Infant-Toddler Social and Emotional Assessment (ITSEA)	30
96111	McCarthy Screening Test	30
96111	Otis-Lenon School Ability Test	30
96111	Piers-Harris Children's Self Concept Scale	30
96111	Temperament and Atypical Behavior Scale (TABS) Assessment Tool	30
96111	Vineland Adaptive Behavior Scales	30
96111	Vineland Mal Adaptive Skill	30
96111	Vineland Social-Emotional Early Childhood Scales	30
96111	Vineland Social Maturity Scale	30

Medical Equipment - Billed with a unit of 1		
Procedure Code	Description	Category of Service
A9900	Equipment	41
Medically necessary equipment may be claimed up to a total of $1,000 per day. Equipment costing more than $1,000 must be obtained through a Medicaid enrolled durable medical equipment (DME) provider.		

Medical Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
T1018	Medical Services	01

Medical Supplies - Billed with a unit of 1		
Procedure Code	Description	Category of Service
99070	Medical Supplies	48
Medically necessary supplies may be claimed up to a total of $500 per day. Supplies exceeding more than $500 per day must be procured through a Medicaid enrolled durable medical equipment and supplies (DME) provider.		

Medication Administration - Billed in units of 5 minute increments with Modifier KO with a maximum billable quantity of 3 units		
Procedure Code	Description	Category of Service
T1502	RN, LPN, Certified School Nurses	10
Registered Nurses (RN), licensed practical nurses (LPN) working under the supervision of RNs, and certified school nurses may use this code when dispensing medication to eligible students.		

Nursing Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
T1002	RN Services	10
T1003	LPN Services	10

Occupational Therapy - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
97535	Individual Occupational Therapy	12
97799	Group Occupational Therapy	12

Physical Therapy - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
97110	Individual Physical Therapy	11
97150	Group Physical Therapy	11

Psychological Services - Billed in units of 15 minute increments with Modifier AH with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
90810 obsolete 12/31/12	Individual Psychological Service	59
90832 effective 1/1/13	Individual Psychological Service	59
90853	Group Psychological Service	59

School Health Aide (SHA) - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
T1021	School Health Aide	93

Social Work Services - Billed in units of 15 minute increments with Modifier AJ with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
96152	Individual Social Work	58
96153	Group Social Work	58

Speech/Language Services - Billed in units of 15 minute increments with a maximum billable quantity of 32 units		
Procedure Code	Description	Category of Service
92507	Individual Speech Therapy	13
92508	Group Speech Therapy	13

Transportation - Billed with a unit of 1		
Procedure Code	Description	Category of Service
A0130	Medicar	52
A0120	Private Automobile	55
T2004	Service Car	54
One or more one way or round trips to source of medical care not to exceed 100 miles per day.		

Taxicab Services - Billed with a unit of 1		
Procedure Code	Description	Category of Service
A0100	Taxicab	53
One or more one way or round trips to source of medical care not to exceed 50 miles per day.		

Other Transportation - Billed with a unit of 1		
Procedure Code	Description	Category of Service
T2003	Transportation	56
One or more round trips to source of medical care per day when another Medicaid/SCHIP service is provided.		

Note: Seven minutes of face-to-face service must be provided in order to claim one unit. 1 unit equals 15 minutes. When the service time is greater than one unit 7 minutes, enter 2 units. When the service time is less than one unit 7 minutes, round down to the lesser unit, enter one unit.

Appendix U-3
Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date the signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic U 201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet.

Field	Explanation
Provider Key	This number uniquely identifies the provider, and is used internally by the department. It is linked to the reported NPI(s).
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the department's records. The three-digit **County** code identifies the county where the provider is located. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information reflecting the manner in which the provider is enrolled with the department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

<table>
<tr><th>Field</th><th>Explanation</th></tr>
<tr><td></td><td>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 = Sole Proprietary
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. Cost report requirements are also indicated. The possible codes are:
B = Active, Cost Report Not Required
I = Inactive
N = Non Participating
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 = Intent to Terminate
B = Expired License
C = Citation to Discover Assets
D = Delinquent Child Support
E = Provider Review
F = Fraud Investigations
G = Garnishment
I = Indictment
L = Student Loan Suspensions
R = Intent to Terminate/Recovery
S = Exception Requested by Provider Participation Unit
T = Tax Levy
X = Tax Suspensions
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.</td></tr>
</table>

Field	Explanation
Categories of Service	This area identifies the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. Each entry is followed by the date on which the provider was approved to render services for each category listed. The Provider Enrollment Application (HFS 2243) defines all applicable categories of services.
Payee **Information**	This area records the name and address of the entity authorized to receive payments on behalf of the provider. The payee is assigned a single-digit **Payee Code.**
	Payee ID Number is a sixteen-digit identification number assigned to each payee, for whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
NPI	The National Provider Identification Number contained in the department's database.
Signature	The provider is required to affix an original signature when submitting changes to the Department of Healthcare and Family Services.

Appendix U-3a
Reduced Facsimile of Provider Information Sheet

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                                                  STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS)                            HEALTHCARE AND FAMILY SERVICES                        RUN DATE: 10/16/13
PROVIDER SUBSYSTEM                                                                                      RUN TIME: 11:47:06
REPORT ID:  A2741KD1                                 PROVIDER INFORMATION SHEET                       MAINT DATE: 10/16/13
SEQUENCE:   PROVIDER TYPE                                                                                   PAGE:    84
            PROVIDER NAME
                                                    PROVIDER TYPE:         047 - LOCAL EDUCATION AGENCY
- -PROVIDER KEY- -  PROVIDER NAME AND ADDRESS
                                                    ORGANIZATION TYPE:      03 - CORPORATION
    000011111111
                                                    ENROLLMENT STATUS        B - ACTIV NO CST    BEGIN 09/05/13 END ACTIVE

                                                    EXCEPTION INDICATOR        - NO EXCEPT       BEGIN          END

                                                             CERTIFIC/LICENSE NUM -          ENDING
                    RE-ENRL IND:  N    DATE:
  INSTUTION INFORMATION:                                     CLIA #:

  INSTITUTION BED CNT:    INST BED:  BEGIN                   LAST TRANSACTION ADD            AS OF 10/16/13   MEDICARE #

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

                                              ELIG                                                  ELIG           TERMINATION

 COS    ELIGIBILITY CATEGORY OF SERVICE    BEG DATE     COS    ELIGIBLITY CATEGORY OF SERVICE   BEG DATE               REASON

 PAYEE

 CODE       PAYEE NAME                 PAYEE STREET          PAYEE CITY         ST  ZIP    PAYEE ID NUMBER   DMERC#     EFF DATE

  1

    *** 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 U-4

HFS
School-Based Health Services
IEP/IFSP Services Activity Log

Student Name:

Date of Birth:

School/LEA:

Type of Service Provided
(As listed in Appendix U-2 in Chapter U-200):

____

Date of Service MM/DD/YY	**Time Spent**	**Number of Children in Group**	**Service Description** Results, response, case notes; must relate to IEP/IFSP goals/objectives

Signature ____________________________________

Date__________________________
Service Provider/Practitioner

Typed/Printed Name____

Appendix U-5

A completed copy of the Verification Statement may be retained in the practitioner credential record as verification that the practitioner is not terminated, suspended, or barred from the Medicaid or Medicare program.

Verification Statement

(Name):____,

Practitioner at (Name of LEA):____,

has been verified as not being terminated, suspended, or barred from the Medicaid or

Medicare program. Electronic look ups can be obtained at the OIG Sanction List and at HHS Sanction list.

This verification was performed by (Name):_________________________________

Date of verification:_________________________________