APPENDIX T-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM HFS 2209, TRANSPORTATION INVOICE

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

- 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 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 Transportation 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 to the provision of provider 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** – Non-Emergency Transportation Providers- Enter the provider number exactly as it appears on the Provider Information Sheet. Emergency Transportation Providers- Enter the NPI number.
Required	**3. Billing Date** – Enter the date the Transportation Invoice was prepared. Use the six digits, MMDDYY format. (January 15, 2001, is entered as 011501)
Optional	**4. Provider Reference** – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed the same data will appear on the provider copy of Form HFS 194-M-1, Remittance Advice.
Optional	**5. Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the department will not attempt corrections.

Optional

6. **Provider City, State, ZIP** – Enter the city, state, and ZIP code of your office. (See Item 5 above)

Required

7. **Recipient Name (First, MI, Last)** – Enter the participant's name exactly as it appears on the Medical Program Card. Separate the name (first, middle initial, last name) by leaving one space between each component. Enter the first name beginning at the left margin of the box.

Required

8. **Recipient Identification Number (RIN)** – Enter the nine-digit RIN assigned to the individual on the Medical Program Card. Do not use the Case Identification Number.

   If the Temporary MediPlan Card does not contain the RIN, attach a copy of the Card to the invoice on first submittal. The department will review the claim and determine the correct RIN. The invoice must be submitted in the pre-addressed envelope, HFS 2248, Special Approval Envelope.

Conditionally Required

9. **Birth date** – This entry is required when the Form HFS 1411, Temporary MediPlan Card does not contain a RIN. Use the six-digit, MMDDYY format. (January 28, 2000, is entered as 012800.)

Required

10. **Vehicle License Number** – Enter the vehicle license plate number of the vehicle used for this trip. Please note- This field applies to emergency and non-emergency services. (Include alpha characters if they are part of the license number.)

Optional

11. **Service Sections (1 through 8)** – One Service Section is to be completed for each procedure code billed. Do not leave a Service Section blank between two completed Service Sections. Providers may complete from one (1) to eight (8) Service Sections per invoice according to the number of services provided.

Required

Date of Service – Enter the date on which the transportation service was provided. The MMDDYY format must be used. (January 28, 2001, is entered as 012801.) Multiple dates of service may be billed on the same invoice.

Required

Category of Service (Cat Serv) – Enter the appropriate code from the list below.

50 - Emergency Ambulance or Helicopter
51 - Non-emergency Ambulance
52 - Medicar
53 - Taxicab

54 - Service Car
55 - Private Automobile
56 - Other

Required **Procedure Code** – For services requiring prior approval, enter the "Approved Procedure Code." For services that do not require prior approval, enter the appropriate code from the provider information sheet.

All providers must bill the appropriate mileage code and charge for each one-way trip. Two procedure codes and two Service Sections must be completed for round-trip mileage.

Taxicab providers who charge a drop or flag charge are to bill this fee as a base rate and return trip procedure code, as appropriate. The mileage procedure code is to be billed in a separate Service Section. Taxicab providers who do not charge a drop or flag charge are to bill the mileage procedure code only.

Conditionally Required **Prior Approval Number** – This field is required for non-emergency transportation claims. The prior approval number can be found on the prior approval letter generated by the department.

Required **Origin Time** – Enter the time the loaded trip began. Time is to be entered as Military Time (if the loaded trip began at 1:30 p.m., the time would be shown as 1330).

Required **Destination Time** – Enter the time the loaded trip ended at the destination. Time is to be entered as Military Time.

Conditionally Required **Total Loaded Miles** – Enter the total loaded miles one way. When a round trip is provided, two mileage procedure codes and Service Sections must be completed.

Miles are to be rounded up to the nearest mile (e.g., 11.4 miles is rounded "12").

Billing for excess mileage is not allowed.

Required **Provider Charge** – Enter the provider's usual and customary charge for the procedure code shown in this section. Separate dollars and cents in the proper sections of the field.

Conditionally Required **Delete** – When an error has been made that cannot be corrected, enter a single capital "X" to delete the entire Service Section.

Required

Origin Place – Enter the appropriate HCPCS modifier selected from the list below as shown on the prior approval letter.

P - Physician's Office
D - Medical Service (other than P or H)
H - Hospital (Inpatient or Outpatient)
R - Residence

Required

Origin (Facility Name/City or Address/City) – Enter the facility name or origin place address and the city from which the patient was transported. The origin may be a hospital, clinic, long-term care facility, the patient's home address or other location.

Required

Destination Place – Enter the appropriate HCPCS modifier, as shown on the prior approval letter, from the list shown under Origin Place above.

Required

Destination (Facility Name/City or Address/City) – Enter facility name or destination place address and the city to which the patient was transported. The destination may be a hospital, clinic, long-term care facility, the patient's home address, etc.

Conditionally Required

12. TPL Code – When the patient's Medical Program Eligibility card lists a TPL (Third Party Liability) Code, the code is to be entered in this field. If two TPL Codes are listed, both codes are to be entered in this field

If the patient has a Third Party Liability coverage but it is not listed on the Medical Program Card, enter the appropriate TPL Code from the Third Party Liability Resource Code Directory, Chapter 100, General Appendix 9.

If none of the TPL codes are applicable, enter Code "999" and the name of the payment source in Field 13, Uncoded TPL Name.

If there is no third party liability resource, no entries are to be made in Fields 12 and 13.

Conditionally Required

SPENDDOWN – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. If the patient has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form HFS 2432 (Split Billing Transmittal). When a Form HFS 2432 is necessary, Form HFS 2209, Transportation Invoice,

should be completed as follows:

- Enter 906 in the TPL CODE field.
- Enter a 01 in the TPL Status field if there is a patient liability or enter a 04 in the TPL STATUS field if there is no patient liability.
- From the Form HFS 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form 2209. This amount may be $0.00.
- From the Form HFS 2432, enter the DATE from the bottom of the form in the TPL DATE field of the Form HFS 2209.
- The TPL fields must be completed in each Service Section that has the same date of service as the Split Bill day. The Spenddown liability is to be divided and reported to the TPL AMOUNT field of each Service Section that has the same date of service.

Conditionally Required

Status – A two-digit code indicating the disposition of the third party billing must be entered. No entry is required if no third party liability exists. The TPL Status Codes are:

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 goods or services were provided.

03 - TPL Adjudicated - service not covered: TPL Status Code 03 is to be entered when advised by the third party resource that goods or services provided are not covered.

04 - TPL Adjudicated - Spenddown met: TPL Status Code 04 is to be entered when the patient's Form HFS 2432, Split Billing Transmittal, shows $0 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when the patient informs the provider that the third party resources identified on the Medical Eligibility Card 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 an invoice has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 - Not Assigned

09 - Not Assigned

10 - Deductible not met (Medicare excluded): TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that no payment was made for the service because the patient's deductible was not met.

Conditionally Required

13. Uncoded TPL Name – Enter the name of any third party payor coded 999 in the TPL Code field.

If two third parties have issued payment for a service, the names of both parties are to be entered.

Required

14. Number of Sections – Enter the number of Service Sections completed correctly on the invoice.

Required

15. Total Charge – Enter the sum of all Provider Charges submitted on the invoice.

Conditionally Required

16. Total Deductions – Enter the sum of all TPL payments received. If no payments were received, leave blank.

Required

17. Net Charge – Enter the difference between the total charge and total deductions.

Required

18. Signature of Provider/Date – After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the department and will be returned to the provider when possible. The signature date is to be entered in MMDDYY format and may be handwritten, typewritten or computer printed.

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 2244, Transportation 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 Web site at:
http://www.illinois.gov/hfs/MedicalProviders/Forms%20Request/Pages/default.aspx
or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

APPENDIX T-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.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the provider.
- 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 should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not 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 or fasten attachment with staples.

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

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.**

MediPlan Card – the identification card issued monthly by the department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago), All Kids Assist or All Kids Moms and Babies, and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for department consideration of Medicare coinsurance and deductibles.

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 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, 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 (previously billed on HCFA 1491) If provider type is not indicated above, enter a capital “X” in the Practitioner box.
Required	**1. Recipient’s Name** - Enter the recipient’s name (first, middle, last) exactly as it appears on the back of the MediPlan card.
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.

Conditionally Required **4.** **Was Condition Related to** –

A. Recipient's Employment - Treatment for an injury or illness that resulted from recipient's employment, enter a capital "X" in the "Yes" box.

B. Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate.

Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.

Required **5.** **Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number from the MediPlan Card. 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 recipient 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 recipient 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.

Not Required 10B. P.O.S. (Place of Service) – Leave blank.

Not Required 10C. T.O.S. (Type of Service) – Leave blank.

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.

Mileage – Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032.

Anesthesia or Assistant Surgery Services– Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 0001.

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.

Not Required 12. For Modifier Use Only – Leave blank.

Required **13A. Origin of Service** – Enter the facility name or origin place address and city from which the patient was transported.

Required **13B. Modifier** – Enter the first alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).

Required **14A. Destination of Service** – Enter the facility name or destination place address and city from which the patient was transported.

Required **14B. Modifier** – Enter the second alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).

Not Required 15A. Origin of Service – Leave blank.

Not Required 15B. Modifier – Leave blank.

Not Required 16A. Destination of Service – Leave blank.

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-1, 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 recipient's treatments. A written description is not required if a valid ICD-9-CM, or upon implementation, ICD-10, code is entered in Field 18A.

Required **18A. Primary Diagnosis Code** – Enter the valid ICD-9-CM, or upon implementation, ICD-10, diagnosis code for the services rendered.

Optional **18B**. **Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-9-CM, or upon implementation, ICD-10, diagnosis code.

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 recipient'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 recipients for the department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box if accepting assignment.

Required **22. Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the physician/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 physician if the service or item was ordered or referred by a physician.

Referring Physician – a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician – A physician who orders non-physician services for the Recipient such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

Conditionally Required **26.** **Identification Number of Referring Physician** – 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 Unique Physician/Practitioner Identification Number (UPIN). **Claims submitted on, or after, October 1, 2008 enter the ordering/referring physician's NPI number.**

Not Required 27. Medicare Provider ID Number – Leave blank.

Required **28.** **Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code.

Conditionally Required **29A.** **TPL Code** – The TPL Code contained on the Recipient's MediPlan Card is to be entered in this field. If payment was received from a third party resource not listed on the MediPlan Card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. If none of the TPL codes in the General Appendix 9 are applicable to the source of payment, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Fields 30A – 30D.

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 on the MediPlan Card 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.

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. 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 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 yellow copy of the claim should be retained by the provider.

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 Web site at http://www.illinois.gov/hfs/MedicalProviders/Forms%20Request/Pages/default.aspx or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

APPENDIX T-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 your signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic T-201.2 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. A sample of a Provider Information Sheet is attached as Appendix T-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

FIELD	EXPLANATION
(1) **Provider Key**	**Non-Emergency Transportation Providers**: This number uniquely identifies the provider and is to be used as the provider number when billing charges to the department. **Emergency Transportation Providers:** 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.
(2) **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.
(3) **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

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
N = Non Participating

Disregard the term MOCST if it appears in this term.

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
S = Exception Requested by Provider Participation Unit
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 a form HFS 1413 (Provider Agreement) on file. If the value of the field is yes, the provider is eligible to submit claims electronically.

4 **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.

5 **S.S.#** This is the provider's Social Security or FEIN number.

6 **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:
50 - Emergency Ambulance or Helicopter
51 - Non-Emergency Ambulance
52 - Medicar
53 - Taxicab
54 - Service Car
55 - Private Automobile
56 - Other
Each entry is followed by the date that the provider was approved to render services for each category listed.

7 **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.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

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.

8 **NPI**

The National Provider Identification Number contained in the department's provider database.

9 **Signature**

The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services.

APPENDIX T-4

SAMPLE UNIFORM TRIP TICKET FOR PROVIDERS OF SERVICE CAR, MEDICAR AND TAXICAB SERVICES

The sample Uniform Trip Ticket may be used by providers of service car, medicar and taxicab services as a way to document information pertinent to each trip. **The department does not issue this form, or require that providers use it for documentation.** However, it does contain information that can assist providers in fulfilling their record requirements.

Sample
Medicar / Service Car / Taxicab Uniform Trip Ticket

Recipient Information

Name_____ Recipient Identification Number_____

Address_____

Requestor Information

Name_____ Address_____

Vehicle Information

License Plate Number_____ Type of Vehicle: ____Medicar ____Service Car ____Taxicab

Medical Provider Information

Name of Medical Provider_____ Type of Facility_____

Trip Information

Date of Trip _____ Prior Approval Number_____

	Initial Trip	**Return Trip**
Name of Driver	_____	_____
Drop-Off Address	_____	_____
No. of Miles Traveled	_____	_____
Name of Employee Attendant	_____	_____
Pick-Up/Drop-Off Time	_____/_____	_____/_____

Was the recipient accompanied on the trip?	____Yes	____No	____Yes	____No
Was the recipient able to walk unassisted?	____Yes	____No	____Yes	____No
Was a stretcher used?	____Yes	____No	____Yes	____No

Explain the medical necessity of the trip/s if no prior approval was required. Also, explain the need for an attendant or stretcher, if used:

_____

Signature of person completing form_____

Printed Name_____ **Date**_____