



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health
Services

NEWSLETTER

Vol. 12 No. 68

August 2002

TO: Programs of Assertive Community Treatment Providers--**For Action** Hospitals, Independent Clinics, Partial Care/Partial Hospitalization (PC/PH) Programs and Health Maintenance Organizations (HMOs)--**For Information Only (Newsletter Only, No Attachments)**

SUBJECT: Programs of Assertive Community Treatment (PACT) Services for Medicaid/NJ FamilyCare – Plan A Beneficiaries

- ✓ Billing Procedures
- ✓ Prior Authorization
- ✓ Reimbursement

EFFECTIVE: August 1, 2002, for claims with dates of service on or after **September 5, 2001**

PURPOSE: The purpose of the Newsletter is to inform providers of the implementation of PACT services as a Medicaid/NJ FamilyCare – reimbursable service and communicate the policies and procedures providers must follow to receive Medicaid/NJ FamilyCare reimbursement. This newsletter also advises providers of immediate action they must take to submit certain claims to Unisys by August 20, 2002, to meet timely filing deadlines.

****IMMEDIATE ACTION REQUIRED****

Effective **August 1, 2002**, PACT providers must begin submitting claims to Unisys, the Medicaid/NJ FamilyCare fiscal agent, for reimbursement for PACT services rendered to Medicaid/NJ FamilyCare – Plan A beneficiaries on or after September 5, 2001.

CLAIMS WITH DATES OF SERVICE FOR THE TIME PERIOD OF SEPTEMBER 5, 2001 THROUGH SEPTEMBER 30, 2001, MUST BE FILED WITH UNISYS NO LATER THAN AUGUST 20, 2002 TO ENSURE THAT PROPER REIMBURSEMENT IS RECEIVED.

BACKGROUND: Programs of Assertive Community Treatment (PACT) are mental health services provided to individuals at a community level by an interdisciplinary team of professionals. Currently providers are being reimbursed through contracts with the Division of Mental Health Services (DMHS). The mental health services provided by these teams are eligible to be reimbursed as a mental health rehabilitation service under Title XIX of the Social Security Act to eligible Medicaid/NJ FamilyCare – Plan A beneficiaries. The Division of Medical Assistance and Health Services (DMAHS) has been working with the DMHS over the past several months to develop policies associated with the provision of, and reimbursement for, PACT services rendered to eligible Medicaid/NJ FamilyCare – Plan A beneficiaries.

Effective for claims with dates of service on or after **September 5, 2001**, PACT Services are available to Medicaid/NJ FamilyCare – Plan A beneficiaries, age 18 and older, who are facing chronic and severe mental illness and who have not responded to traditional mental health treatment, using the criteria established by the Division of Mental Health Services.

NOTE: NJ FamilyCare – Plans B, C, D, G and H beneficiaries are not eligible to receive PACT services.

ACTION: Effective for claims with dates of service on or after **September 5, 2001**, all PACT teams are required to submit claims for services provided to eligible Medicaid or NJ FamilyCare – Plan A beneficiaries. All PACT services rendered to an eligible Medicaid or NJ FamilyCare beneficiary must be delivered by a provider who is enrolled in the Medicaid/NJ FamilyCare program as a PACT provider. PACT services provided to Medicaid/NJ FamilyCare – Plan A beneficiaries must be prior authorized using DMAHS form FD-07; "Request for Prior Authorization for Mental Health and/or Mental Health Rehabilitation Services."

BILLING PROCEDURES

Providers shall seek reimbursement by submitting a CMS-1500 claim form, using HCPCS procedure code Z3370 as described below.

<u>IND</u>	<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
P	Z3370	Comprehensive PACT Services, monthly (adults)	\$1235.00 (dates of service between 09/05/01 – 06/30/02)
			\$1260.00 (dates of service on or after 07/01/02)

A PACT provider shall not request reimbursement for PACT services when the beneficiary is also receiving mental health Personal Care Assistant (PCA) services during the same month of service.

PRIOR AUTHORIZATION PROCEDURES

A prior authorization number is required to be on all claims so that Unisys, the Medicaid/NJ FamilyCare fiscal agent, can correctly process the claim. This will require the providers submitting claims for services that were provided on or after September 5, 2001 to be issued prior authorization numbers so that those claims can be processed through the system at Unisys.

For claims with the initial date of service on or after September 5, 2001, but before September 1, 2002, providers must complete the FD-07 and attach a copy of the DMHS PACT Referral and Intake Outcome form and submit the form directly to the Statewide PACT Coordinator. The request for prior authorization should be for no more than one year and is required only for those PACT clients who were Medicaid/NJ FamilyCare – Plan A beneficiaries at the time the service was rendered. The forms should be sent to:

Bruce Yellin
PACT Coordinator
Division of Mental Health Services
PO Box 727
Trenton, NJ 08625-0727

IF PROVIDERS HAVE NOT RECEIVED AN APPROVED PRIOR AUTHORIZATION NUMBER FOR CLAIMS WITH DATES OF SERVICE ON OR AFTER SEPTEMBER 5, 2001 BY AUGUST 20, 2002, THE CLAIM MUST BE FILED WITHOUT THE PA NUMBER IN ORDER TO MEET THE TIMELY FILING REQUIREMENTS.

For claims with the initial date of service on or after September 1, 2002, for the provision of PACT services to Medicaid/NJ FamilyCare – Plan A beneficiaries, providers shall request prior authorization as follows:

1. For all individuals being considered for PACT services, the PACT provider shall complete the "DMHS PACT Referral and Intake Outcome" form to request authorization to provide PACT services and submit the form to the DMHS Regional Office in the county in which the provider is located. This form can be obtained from the DMHS Regional Office.
2. The Regional DMHS Program Analyst will evaluate the eligibility of the beneficiary for PACT services in accordance with DMHS standards, and advise the provider of results of the evaluation.
3. Upon receipt of approval, the provider shall meet with the beneficiary, enroll the beneficiary into the PACT program, and return the signed and dated "DMHS PACT

Referral and Intake Outcome" form back to the DMHS Regional Office, confirming the enrollment of the beneficiary into the PACT program.

4. The PACT provider must also complete the DMAHS form FD-07, (Request for Prior Authorization for Mental Health and/or Mental Health Rehabilitation Services), requesting prior authorization for PACT services. All dates entered must accurately reflect the exact date that service will be initiated and the expected termination date of the services. This form and a copy of the completed "DMHS PACT Referral and Intake Outcome" form must be submitted to the Statewide DMHS PACT Coordinator at the address below.

Bruce Yellin
PACT Coordinator
Division of Mental Health Services
PO Box 727
Trenton, NJ 08625-0727

An initial supply of the FD-07 forms has been sent to PACT providers under separate cover. Additional forms may be requested from Unisys.

5. Unisys will notify the providers that services have been authorized. Providers are advised to wait until such authorization is received before providing services.

Medicaid/NJ FamilyCare – Plan A beneficiaries who are receiving PACT services are not, as a general rule, permitted to be enrolled in Partial Care or Partial Hospitalization (PC/PH) programs. However, in those cases where receiving a combination of both services will facilitate the transition of the beneficiary out of receiving the PACT services, limited PC/PH services may be provided if clinically indicated and prior authorization is obtained.

For the provision of **Partial Care/Partial Hospitalization (PC/PH) services to a Medicaid or NJ FamilyCare – Plan A beneficiary who is also enrolled in a PACT program**, the prior authorization procedure is as follows:

1. The PACT provider must submit a written request to the Regional DMHS Program Analyst requesting authorization to enroll a beneficiary receiving PACT services into a Partial Care/Partial Hospitalization (PC/PH) program. The written request shall include a detailed justification for the necessity of the PC/PH services; and
 - ✓ The DMAHS prior authorization request forms must be completed by the PC/PH provider requesting authorization to provide PC/PH services to a beneficiary receiving PACT services for a period not to exceed 30 days as the beneficiary is transitioning out of PACT services.
2. The Regional DMHS Program Analyst will recommend services, if appropriate, and will forward the recommendation for approval of requests for PC/PH services to:

Division of Medical Assistance and Health Services

Office of Customer Service
P.O. Box 712 Mail Code 25
Trenton, NJ 08625-0712.

The DMAHS Office of Customer Service will review the request and advise the Statewide PACT Coordinator of the approval or denial of the request, who will advise the PACT Team of the decision.

3. Unisys will notify the PC/PH providers that services have been authorized. Such authorization should be received before providing services.
 - ✓ PC/PH services will not be approved for more than 30 days for a Medicaid/NJ FamilyCare -- Plan A beneficiary who is also receiving PACT services.
 - ✓ PC/PH services will only be approved as the Medicaid/NJ FamilyCare -- Plan A beneficiary is transitioning out of receiving PACT services.
 - ✓ All dates entered on the PA form must accurately reflect the date that service was initiated and the expected termination date of the service, not to exceed 30 days.

ALL claims filed with Unisys, the Medicaid/NJ FamilyCare fiscal agent, for reimbursement must include the prior authorization number for services rendered in order to ensure that appropriate reimbursement is made. The prior authorization must cover the dates that services were rendered to ensure proper reimbursement.

REIMBURSEMENT REQUIREMENTS

Providers will be reimbursed on a fee-for-service basis for PACT services provided to a Medicaid/NJ FamilyCare -- Plan A beneficiary, based on the lower of the provider's usual and customary charge or the established DMAHS contracted monthly reimbursement rate of \$1235.00 for services provided prior to July 1, 2002, or \$1260.00 for services provided on or after July 1, 2002.

A unit of service is defined as one calendar month of service. Full reimbursement shall be requested the month services are initiated. No reimbursement shall be requested for the month services are terminated.

A minimum of two hours of contact, directly with, or on behalf of, the beneficiary shall be provided each month, with the exception of the initial month of service. If the minimum face to face contact is not achieved during any subsequent calendar month, the provider shall not seek reimbursement for the provision of PACT services to a Medicaid/NJ FamilyCare – Plan A beneficiary during that month.

In calculating the monthly minimum service requirement, do not count face to face contact provided during any time during which the beneficiary was a resident of an Institution for

Mental Disease (IMD), including state, county or private psychiatric hospitals, or when the beneficiary was incarcerated in any correctional facility.

However, if a beneficiary is in one of these settings for only a portion of the calendar month, **and** the minimum monthly service requirement of 2 hours of contact is met during the remainder of the month, that is, when the beneficiary did not reside in an institution or correctional facility, the provider may submit a bill for PACT services for that month.

Inpatient acute care hospitals or medical daycare programs are not considered IMDs. Therefore, the service requirement contact provided to, or on behalf of, a Medicaid or NJ FamilyCare – Plan A beneficiary who is receiving PACT services, while receiving inpatient services in an acute care hospital or medical day care program, may be counted towards the 2 hour monthly minimum service requirement.

Basic Claim Completion Guidelines

NOTE: The CMS 1500 replaces the HCFA 1500. There are no changes to the content of the form, the change simply represents the name change of the agency issuing the forms from the Health Care Financing Administration (HCFA) to The Centers for Medicare & Medicaid Services (CMS). Providers may use either version of the form.

Correctly transfer the prior authorization number to the CMS 1500 claim form. Make sure that the prior authorization number matches the number that is on the notification received from Unisys.

Provide all required information for every claim service detail line. Do not use ditto marks or the words "same as above."

Print the information legibly, completely, and correctly with a typewriter, printer, or ballpoint pen (blue or black ink). Forms that are not legible or that cannot be reproduced because the print is too light will be returned to the provider.

Forward the completed CMS 1500 claim forms to:

Unisys
P.O. Box 4808
Trenton, NJ 08650-4808

NOTE: The total amount claimed on each CMS 1500 claim form (field #28) must not exceed \$5000.00 or the claim will be denied. Providers are advised not to exceed that amount on the claim form; for PACT services, this means that no more than three claim lines should be completed on each form.

****A separate CMS claim form must be completed for each beneficiary.****

Each CMS 1500 claim form must be totaled as an independent submission; the Total Charge (field 28), Amount Paid (field 29) and Balance Due (field 30) must not be continued from one claim form to an additional claim form.

ATTACHMENTS (provided to PACT providers only):

1. An example of the FD-07 form
2. Instructions for the proper completion of the FD-07 form
3. A copy of the DMHS PACT Referral and Intake Outcome Form
4. An example of the CMS 1500
5. Instructions for the proper completion of the CMS 1500 form
6. A New Jersey MMIS Form Request

Additional copies of all forms provided by Unisys may be ordered by completing the NJ MMIS Form Request and submitting the request to: Unisys, P.O. Box 4804, Trenton, NJ 08650-4804. Forms may also be requested from Unisys on their website, www.njmmis.com, or by calling Provider Services at 1-800-776-6334. Allow approximately three (3) weeks for delivery. Please request no more than a three-month supply of forms at one time.

For copies of the DMHS PACT Referral and Intake Outcome form, please contact your DMHS Regional Office.

Questions?

If you have any general questions regarding prior authorization services, please call the Office of Utilization Management, Mental Health Services Unit, at (609) 588-2726.

If you have any questions regarding prior authorization procedures for a PACT client to receive limited PC/PH services, please contact the Office of Customer Service, at (609) 631-4641.

If you have any questions regarding billing procedures, please contact Unisys Provider Services at: 1-800-776-6334.

**RETAIN THIS MEDICAID NEWSLETTER CHRONOLOGICALLY BEHIND THE
MEDICAID NEWSLETTER TAB (BLUE TAB MARKED "5")**

GENERAL INFORMATION RELATED TO REQUESTING PRIOR AUTHORIZATION FOR PACT SERVICES

The form that Medicaid/NJ FamilyCare – enrolled providers of Programs for Assertive Community Treatment (PACT) services must use to request prior authorization for the provision of mental health services to eligible beneficiaries is the:

- FD-07 (rev. 09/01): Request For Prior Authorization For Mental Health Services and/or Mental Health Rehabilitation Services

The FD-07 is a two-ply form that must be used when a provider is requesting approval for any mental health service requiring prior authorization. This form has a pre-printed number in the upper right hand corner that is the prior authorization number; however, until the PA letter is received, the number is not valid for use on claim forms.

General Prior Authorization Guidelines

- Include all the necessary information to support the request for authorization;
- Enter all dates in a month, day, and year sequence (MM/DD/YY). For example, September 10, 1995 is entered 091095;
- Provide all required information for every prior authorization service detail line;
- Include the "cents" positions for all dollar amounts but do not use a decimal point and do not use a dollar sign. For example, enter 2500, **not** 25.00 or 25; and
- Verify the accuracy of all information before submitting the appropriate form for prior authorization.

NOTE: Please print or type all information. Forms that are not legible will be returned to the provider.

Prior authorization requests for **PACT Services** should be submitted to the Statewide DMHS PACT Coordinator along with a copy of the "DMHS PACT Referral and Intake Outcome" form. These forms should be sent to:

PACT Coordinator
Division of Mental Health Services
PO Box 727
Trenton, NJ 08625-0727

Prior Authorization requests for Partial Care or Partial Hospitalization services to be provided to an individual who is receiving PACT services should be submitted to the appropriate the Regional DMHS Program Analyst.

EFFECTIVE: September, 2001

FORM LOCATOR 1

DATA ELEMENT: Beneficiary's Last Name/First Name/M.I.

Definition:

Instruction: Enter beneficiary's name as it appears on the Medicaid/NJ FamilyCare/Children's System of Care Initiative (CSOCI) Eligibility Identification Card. Last name, first name, middle initial (M.I.).

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 2

DATA ELEMENT: Beneficiary's Street Address/Telephone Number

Definition:

Instruction: Enter beneficiary's complete address and telephone number.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 3

DATA ELEMENT: HSP (Medicaid/NJ FamilyCare or CSOCI) Case Number

Definition:

Instruction: Enter the first ten digits of the beneficiary's Medicaid/NJ FamilyCare Identification number EXACTLY as they appear on the Identification Card.

Field Characteristics:

Values:

Notes:

.

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 4

DATA ELEMENT: Person Number

Definition:

Instruction: Enter the last two digits of the beneficiary's Medicaid/NJ FamilyCare Identification number EXACTLY as they appear on the Identification Card.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 5

DATA ELEMENT: Date of Birth

Definition:

Instruction: Enter the beneficiary's date of birth in month, day and year sequence (MM/DD/YY). For example, September 10, 1981 is entered as 09/10/81.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 6

DATA ELEMENT: Sex

Definition:

Instruction: Check the appropriate block to indicate beneficiary's sex.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 7

DATA ELEMENT: Place of Service - Name and Address

Definition:

Instruction: Enter the name and address of the location where the service will be provided.

For PACT services, enter "COMMUNITY"

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 8

DATA ELEMENT: Provider of Service Information

Definition:

Instruction: Enter the provider's name, address, telephone number and seven-digit Medicaid/NJ FamilyCare provider number.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 9

DATA ELEMENT: Brief Clinical History

Definition:

Instruction: Enter a brief clinical history of beneficiary. Include the date and location of the beneficiary's last treatment or hospitalization.

Note: Providers using the FD-07 (rev. 09/01) enter this information at #9a on the FD-07A (rev. 09/01).

PACT providers do not need to complete this field. They are required to attach the DMHS PACT Referral and Intake Outcome" form.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 10

DATA ELEMENT: Present Clinical Status

Definition:

Instruction: Enter the current clinical status of the beneficiary.

Note: Providers using the FD-07 (rev. 09/01) enter this information at #10a on the FD-07A (rev. 09/01).

PACT providers do not need to complete this field. They are required to attach the "DMHS PACT Referral and Intake Outcome" form.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 11

DATA ELEMENT: Diagnosis and Code and Current Medications

Definition:

Instruction: Enter a valid and appropriate ICD-9-CM diagnosis code and a brief narrative description of the diagnosis. List name, dose and frequency of currently medications.

Note: Providers using the FD-07 (rev. 09/01) enter this information at #11a on the FD-07A (rev. 09/01).

PACT providers do not need to complete this field. They are required to attach the DMHS PACT Referral and Intake Outcome" form.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 12

DATA ELEMENT: Treatment Request

Definition:

Instruction: Enter the number of visits that have been included in the treatment plan and check the box that indicates the length of each session. Enter the code number for each psychological test that is included in the treatment plan.

If you check "other" please specify the service requested.

Field Characteristics:

Values:

Notes: For PACT services, enter the words "PACT Services" next to "other" and check the box indicating that these services are billed for monthly.

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 13

DATA ELEMENT: Requested Date(s)

Definition:

Instruction: Enter the requested from and through dates of service in month, day and year sequence (MM/DD/YY)

Field Characteristics:

Values:

Notes: PACT services can be requested for up to 12 months at a time

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 14

DATA ELEMENT: Authorized Date(s):

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 15

DATA ELEMENT: Reviewer ID/Review Date

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16

DATA ELEMENT: Prior Authorized Services Detail

Definition:

Instruction:

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16A

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16B

DATA ELEMENT: Revenue Code or Procedure & Modifier Code Requested

Definition:

Instruction: Enter the Revenue Code or the appropriate five-digit HCPCS procedure code and two-digit modifier (if applicable). A list of appropriate HCPCS codes can be found in the Medicaid/NJ FamilyCare Provider Manual. Definitions of the Level I procedure codes are found in the American Medical Association Physicians' Current Procedure Terminology.

Field Characteristics:

Values:

Notes: For PACT services, use the Level III HCPCS procedure code "Z3370"

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16C

DATA ELEMENT: Revenue Code or Procedure & Modifier Code Approved:

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16D

DATA ELEMENT: Units Requested

Definition:

Instruction: Enter the number of days or other units of service (visits) as applicable.

Field Characteristics:

Values:

Notes: For PACT services, a unit of service is one month, during which 2 hours of direct or collateral contact must be provided in order to receive reimbursement.

PACT providers may request authorization for up to 12 months on one form.

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16E

DATA ELEMENT: Units Approved

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16F

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16G

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16H

DATA ELEMENT: Description of Service

Definition:

Instruction: Enter a brief description of service(s) to be rendered.

Field Characteristics:

Values:

Notes: For PACT services, enter "PACT"

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16I

DATA ELEMENT: Total Fee Requested

Definition:

Instruction:

Field Characteristics:

Values:

Notes: Completion of this field is not required for PACT providers

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16J

DATA ELEMENT: Total Fee Approved

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16K

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16L

DATA ELEMENT: Status

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

**"PROGRAMS OF ASSERTIVE COMMUNITY
TREATMENT (PACT) SERVICES"**

SAMPLE

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA HEALTH INSURANCE CLAIM FORM PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123456789002										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) VAN PELT, LUCILLE					3. PATIENT'S BIRTH DATE MM DD YY 10 15 62 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)										
5. PATIENT'S ADDRESS (No., Street) 321 MAIN STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)										
CITY HOMETOWN			STATE NJ		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>					CITY			STATE							
ZIP CODE 01234		TELEPHONE (Include Area Code) (609) 555-1234			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>					ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER										
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME										
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME										
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment SIGNED SIGNATURE ON FILE DATE 12-31-01										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED										
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17A. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. . 296 3. . . 2. . . 4. . .										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										
23. PRIOR AUTHORIZATION NUMBER 1234567012																				
24. A		B		C		D			E		F		G	H	I	J	K			
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) OPT/HPCPS MODIFIER			DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE			
09 07 01 09 30 01		99 99		Z5008			1		1235 00		1									
10 01 01 10 31 01		99 99		Z5008			1		1235 00		1									
11 01 01 11 30 01		99 99		Z5008			1		1235 00		1									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. AB123456					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE 3705 00		29. AMOUNT PAID		30. BALANCE DUE 3705 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Original Signature</i> SIGNED DATE 08/02/02					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 609-555-5678 NEIGHBORHOOD PACT AGENCY 568 WASHINGTON RD. HOMETOWN, NJ 01234 PIN # GRP # 1234567										

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

EFFECTIVE: July 1, 1995

FORM LOCATOR 1

DATA ELEMENT: Coverage indicator

Definition:

Instruction: Place an "X" in the box for Medicaid when billing for PACT services provided to a Medicaid/NJ FamilyCare – Plan A beneficiary.

Field Characteristics: Alpha
1 position

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 1a

DATA ELEMENT: Insured's I.D. Number

Definition: The twelve (12) digit number that designates the beneficiary's Medicaid/NJ FamilyCare identification number.

Instruction: Enter the beneficiary's identification number and person number **EXACTLY** as printed on the Medicaid/NJ FamilyCare Eligibility Identification card.

Field Characteristics: Numeric
12 positions

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 2

DATA ELEMENT: Patient's Name

Definition: Last name, first name and middle initial of the patient.

Instruction: Copy the beneficiary's name **EXACTLY** as printed on the Medicaid/NJ FamilyCare Eligibility Identification Card. Last name must be entered first.

Field Characteristics: Alpha

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 3

DATA ELEMENT: Patient's Birthdate and Sex

Definition: The date of birth of the patient and the sex of the patient as recorded at the date of service.

Instruction: Enter the patient's date of birth in month, day, year (MMDDYY) format. For example, September 10, 1971 is entered as 091071. Enter an "X" in the appropriate box that identifies the sex of the beneficiary.

Field Characteristics:	<u>Birthdate</u>	<u>Sex</u>
	Numeric 6 positions	Alpha 1 position

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 4

DATA ELEMENT: Insured's Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 5

DATA ELEMENT: Patient's Address

Definition: The location of the patient's legal address.

Instruction: Enter the patient's legal address as it appears on his or her Medicaid/NJ FamilyCare Identification Card.

Field Characteristics:

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 6

DATA ELEMENT: Patient Relationship to Insured

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 7

DATA ELEMENT: Insured's Address

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 8

DATA ELEMENT: Patient Status

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 9

DATA ELEMENT: Other Insured's Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 9a

DATA ELEMENT: Other Insured's Policy or Group Number

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 9b

DATA ELEMENT: Other Insured's Date of Birth/Sex

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 9c

DATA ELEMENT: Employer's Name or School Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 9d

DATA ELEMENT: Insurance Plan Name or Program Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 10abc

DATA ELEMENT: Is Patient's Condition Related To:

Definition: Indicates whether service(s) are related to employment, auto accident or other accident.

Instruction: Enter an "X" in the appropriate "YES" or "NO" block to indicate whether the patient's condition is related to employment, auto accident or other accident.

Field Characteristics: Alpha
1 position

Values:

Notes:

EFFECTIVE: July 1, 1995

FORM LOCATOR 10d

DATA ELEMENT: Reserved For Local Use

Definition: Carrier code is a three-digit code assigned to identify the beneficiary's other insurance carrier.

Instruction: Enter the three-digit health insurance carrier code.

Field Characteristics: Numeric
9 positions

Values:

- Notes:**
1. A list of carrier codes is included in Appendix "D" of the Provider Manual.
 2. If the beneficiary has Medicare coverage, the carrier code(s) for Medicare must be entered in this field.
 3. Up to three carrier codes may be entered in this form locator.

EFFECTIVE: July 1,

OR
1995

FORM LOCATOR 11

DATA ELEMENT: Insured's Policy Group or FECA Number

Definition: Insured's policy group identification number assigned by the payer.

Instruction: Enter the policy group number.

Field Characteristics: Alpha-numeric

Values:

Notes:

\

EFFECTIVE: July 1, 1995

OR

FORM LOCATOR 11a

CMS 1500

DATA ELEMENT: Insured's Date of Birth/Sex

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1, 1995

NR

FORM LOCATOR 11b

DATA ELEMENT: Employer's Name or School Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1, 1995

NR

FORM LOCATOR 11c

DATA ELEMENT: Insurance Plan Name or Program Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1, 1995

FORM LOCATOR 11d

DATA ELEMENT: Is There Another Health Benefit Plan

Definition: Indicates whether the beneficiary has other health insurance coverage.

Instruction: Enter an "X" in the appropriate "YES" or "NO" block to indicate whether the beneficiary has other health insurance coverage.

Field Characteristics: Alpha
1 position

Values:

Notes: If form locator 10D is completed this form locator must be marked yes.

EFFECTIVE: July 1, 1995

OR

FORM LOCATOR 12

DATA ELEMENT: Patient's or Authorized Person's Signature

Definition: The patient's signature, date and relationship, if other than the patient.

Instruction: The patient or authorized representative must sign and enter the date in MMDDYY sequence. The patient's signature is waived if "Beneficiary signature on file" is entered in this space.

Field Characteristics: Alpha-numeric

Values:

- Notes:**
1. The claim form will be returned if this space is left blank.
 2. If the patient signature is unobtainable, refer to N.J.A.C. 10:49 (Administration) Chapter 1 of the Provider Manual for procedures to follow for acceptable alternate signatures.

R

EFFECTIVE: July 1, 1995

FORM LOCATOR: 13

CMS 1500

DATA ELEMENT: Insured's or Authorized Person's Signature

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1,

NR
1995

FORM LOCATOR 14

DATA ELEMENT: Date of Current Illness

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1, 1995

NR

FORM LOCATOR 15

CMS 1500

DATA ELEMENT: If Patient Has Had Same or Similar Illness

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1, 1995

NR

FORM LOCATOR 16

DATA ELEMENT: Dates Patient Unable to Work in Current Occupation

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 17

DATA ELEMENT: Name of Referring Physician or Other Source

Definition: The name of the referring physician.

Instruction: Enter the name of the referring physician or practitioner.

Field Characteristics: Alpha

Values:

Notes: For PACT services, it is not necessary to complete this field.

EFFECTIVE: July 1,

OR

 1995

FORM LOCATOR 17a

DATA ELEMENT: I.D. Number of Referring Physician

Definition:

Instruction: Enter the referring physician's seven (7) digit Medicaid/NJ FamilyCare provider number.

Field Characteristics: Numeric
7 positions

Values:

Notes: For PACT services it is not necessary to complete this field

EFFECTIVE: July 1, 1995

OR

FORM LOCATOR 18

DATA ELEMENT: Hospitalization Dates Related To Current Services

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

EFFECTIVE: July 1, 1995

NR

FORM LOCATOR 19

DATA ELEMENT: Reserved For Local Use

Definition:

Instruction:

Field Characteristics: Numeric
10 positions

Values:

Notes:

EFFECTIVE: July 1, 1995

OR

FORM LOCATOR 20

CMS 1500

DATA ELEMENT: Outside Lab? \$Charges

Definition: Indicates whether there were outside lab charges.

Instruction: Enter an "X" in the appropriate "YES" or "NO" block to indicate whether there were outside lab charges.

Field Characteristics: Alpha
1 position

Values:

Notes: Not required for PACT services

EFFECTIVE: July 1, 1995

NR

FORM LOCATOR 21

CMS 1500

DATA ELEMENT: Diagnosis or Nature of Illness or Injury

Definition: The ICD-9-CM code(s).

Instruction: Enter the ICD-9-CM code(s) which describe the diagnosis.

Field Characteristics: Alpha-numeric
5 positions

Values:

Notes: Enter the code only as it appears in the ICD-9-CM.
Do not enter any additional leading or trailing zeros to the code.

R

EFFECTIVE: July 1, 1995

FORM LOCATOR: 22

CMS 1500

DATA ELEMENT: Medicaid Resubmission Code/Original Ref. No.

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 23

DATA ELEMENT: Prior Authorization Number

Definition: The number that authorizes the service(s) provided

Instruction: Enter the Prior Authorization number for this service.

Field Characteristics: Numeric
10 positions

Values:

Notes:

OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 24a

CMS 1500

DATA ELEMENT: Dates of Service

Definition: The beginning and ending service dates.

Instruction: Enter the "from" and "to" dates of service to which this claim applies in month, day and year sequence (MMDDYY).

Field Characteristics: Numeric
12 positions

Values:

Notes: For PACT services, dates of services should reflect the actual days that services were rendered during the entire month and indicate one unit of service. Enter each month on a separate line, do not span from month to month.

For example:

09/05/01 – 09/30/01	one unit of service
10/01/01 – 10/31/01	one unit of service
11/01/01 – 11/30/01	one unit of service
12/01/01 – 12/15/01	termination month: no reimbursement provided

Providers shall be reimbursed for the month that the services are initiated, regardless of the exact date in the month services were initiated. Providers shall not be reimbursed for services during the month the services are terminated, regardless of the exact date the beneficiary was discharged from CMO services during the month. Exact initiation and termination dates must be entered for the beginning and ending months of PACT services.

EFFECTIVE: July 1, 1995

R

FORM LOCATOR 24b

CMS 1500

DATA ELEMENT: Place of Service

Definition: The place where services were performed.

Instruction: Enter the place of service for each procedure performed.

Field Characteristics: Numeric
2 positions

Values:

- 11- Office
- 12- Home
- 21- Inpatient Hospital
- 22- Outpatient Hospital
- 23- Emergency Room- Hospital
- 24- Ambulatory Surgical Center
- 31- Skilled Nursing Home
- 32- Nursing Facility
- 33- Custodial Care facility
- 34- Hospice
- 51- Inpatient Psychiatric facility
- 52- Psychiatric Facility Partial hospital
- 53- Community Mental Health facility
- 54- Intermediate Care facility
- 55- Residential Substance Abuse Treatment facility
- 56- Psychiatric Residential Treatment Center
- 65- End Stage Renal Disease Treat. facility
- 99- Other

Notes: For PACT services, enter "99"

EFFECTIVE: July 1, 1995

FORM LOCATOR 24c

DATA ELEMENT: Type of Service

Definition: The type of services that were performed

Instruction: Enter the type of service for each procedure performed.

Field Characteristics: Numeric
 2 positions

Values: 01- Medical Care
 02- Surgery
 03- Consultation
 04- Diagnostic X-ray
 05- Diagnostic Lab
 06- Radiation Therapy
 07- Anesthesia
 08- Surgical Assistance
 09- Other Medical Service
 10- Blood charges
 11- Used DME
 12- DME Purchase
 13- ASC facility
 14- Renal Supplies in the Home
 15- Alternate Method Dialysis Payment
 16- CRD Equipment
 17- Pre-Admission Testing
 18- DME Rental
 19- Pneumonia Vaccine
 20- Second Surgical Opinion
 21- Third Surgical Opinion
 99- Other

Notes: For PACT services, enter "99"

EFFECTIVE: July 1, 1995

FORM LOCATOR 24d

DATA ELEMENT: Procedures, Services, or Supplies

Definition: The procedure code is a five (5) digit code for all medical procedures covered by Medicaid/NJ FamilyCare

Instruction: Enter the appropriate five digit HCPCS procedure code and as many as two two-digit modifiers (if applicable) for each service provided.

Field Characteristics: Alpha-numeric
9 positions

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 24e

DATA ELEMENT: Diagnosis Code

Definition:

Instruction: Enter the reference number that corresponds with the diagnosis code in form locator 21.

Field Characteristics: Alpha-numeric
5 positions

Values:

Notes:

EFFECTIVE: July 1, 1995

FORM LOCATOR 24f

CMS 1500

DATA ELEMENT: (\$) Charges

Definition: The usual and customary charge.

Instruction: Enter the usual and customary charge for each service or procedure.

Field Characteristics: Numeric
9 positions

Values:

Notes: This amount must reflect the total charge for the claim service detail line.

Do not use decimal points (.) or a dollar sign (\$).
For example: \$25.00 should be entered as 2500.

EFFECTIVE: July 1, 1995

FORM LOCATOR 24g

CMS 1500

DATA ELEMENT: Days or Units

Definition: The number of days or units for each service.

Instruction: Enter the number of units of service.

Field Characteristics: Numeric
4 positions

Values:

Notes: For PACT services, one unit of service represents one calendar month of services.

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 24h

DATA ELEMENT: EPSDT Family Planning

Definition:

Instruction: If the service is an EPSDT referral and/or family planning, enter the appropriate value.

Field Characteristics: 1 position

Values:
1 - EPSDT Referral
2 - Family Planning
3 - EPSDT Referral and Family Planning

Notes:

OR

EFFECTIVE: July 1, 1995

FORM LOCATOR 24i

DATA ELEMENT: EMG

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 24j

DATA ELEMENT: COB

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 24k

DATA ELEMENT: Reserved For Local Use

Definition: The seven digit provider number of the servicing provider.

Instruction: Enter the seven digit Medicaid/NJ FamilyCare provider number of the servicing physician only when the provider number in 33 is a group provider billing number and there was more than one servicing provider for the services billed. If multiple services are billed, but only one servicing provider than indicate the servicing provider number in form locator 33 PIN.

Field Characteristics: Numeric
7 positions

Values:

Notes: For children receiving PACT services, this field is not required.

OR

EFFECTIVE: July 1, 1995

FORM LOCATOR 25

DATA ELEMENT: Federal Tax ID Number

Definition: Shared Health Care Facility number.

Instruction: Enter the Shared Health Care Facility (SHCF) provider number.

Field Characteristics: Numeric
7 positions

Values:

Notes:

OR

EFFECTIVE: July 1, 1995

FORM LOCATOR 26

DATA ELEMENT: Patient's Account Number

Definition: The provider's internal account number for the beneficiary.

Instruction: Enter up to 16 alpha or numeric characters of the provider's internal account number or the beneficiary's last name.

Field Characteristics: Alpha-numeric
16 positions

Values:

Notes: This information will be printed on the Remittance Advice and may help with your account reconciliation.

OR

EFFECTIVE: July 1, 1995

FORM LOCATOR 27

DATA ELEMENT: Accept Assignment?

Definition:

Instruction: Not required.

Leave this section blank. DO NOT check "No"

Field Characteristics:

Values:

Notes:

NR

EFFECTIVE: July 1, 1995

FORM LOCATOR 28

DATA ELEMENT: Total Charge

Definition: The sum of charges for all detail lines.

Instruction: Add the amounts from each claim service detail line 24F, "charges" and enter the total.

Field Characteristics: Numeric
9 positions

Values:

Notes: 1. Do not use decimal points (.) or dollar signs (\$).
\$3500.00 should be entered as 350000

R

CMS 1500

EFFECTIVE: July 1, 1995

FORM LOCATOR 29

DATA ELEMENT: Amount Paid

Definition: Amount paid by other sources.

Instruction: Enter any amount already paid by sources other than Medicare.

Field Characteristics: Numeric
9 positions

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 30

DATA ELEMENT: Balance Due

Definition: Balance due from Medicaid/NJ FamilyCare.

Instruction: Enter balance due from Medicaid/NJ FamilyCare. (Form Locator 28 less Form Locator 29.)

Field Characteristics: Numeric
9 positions

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 31

DATA ELEMENT: Signature of Physician or Supplier Including Degree or Credentials

Definition: An authorized signature indicating that the information entered on the face of this claim is in conformance with the certification on the back of the claim form.

Instruction: Read the certification on the reverse side of the CMS 1500 form. Sign and date the form accordingly.

Field Characteristics: Alpha-numeric

Values:

Notes:

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 32

DATA ELEMENT: Name and Address of Facility Where Services Were Rendered

Definition: Where the services were performed.

Instruction: Enter the name and address of the facility where service was rendered, if other than the provider's location or the beneficiary's home.

Field Characteristics: Alpha-numeric

Values:

Notes: This field not required for PACT services

OR

EFFECTIVE: July 1, 1995

FORM LOCATOR 33

DATA ELEMENT: Physician's, Supplier's Billing Name, Address, Zip Code and Phone Number

Definition: The provider's name, address, phone number and Medicaid/NJ FamilyCare billing provider number.

Instruction: Enter the provider's name, address, telephone number, and seven digit Medicaid/NJ FamilyCare provider number.

SEE NOTES

Field Characteristics: Alpha-numeric

Values:

Notes: Enter the group/billing Medicaid/NJ FamilyCare provider number to the right of GRP#.

Do not enter any numbers next to "PIN"

R

NEW JERSEY MMIS FORM REQUEST

Provider Name: _____ Provider # _____

Mailing Street Address: _____ IMPRINT FORMS
 (Do Not Use PO Box) (EXCEPT MC-6)
 Yes No

City/State/Zip: _____

INSTRUCTIONS: Type or print your name, provider number, and full address above. Below, indicate the type and quantity of forms desired. Maximum order = 3 Months, please indicate number of claim forms. UNISYS will imprint **claim forms** (except MC-6) with Provider name, address and Provider number unless declined by the provider.

<u>Quantity Needed</u>	<u>Form Number</u>	<u>Form Title</u>
_____	MC-6	Prescription Claim Form
_____	*MC-9	Request for Authorization and Payment--Optical Appliances
_____	*MC-10	Dental Prior Authorization/Claim Form
_____	MC-12	Transportation Claim Form
_____	MC-19	Report and Claim Form for EPSDT/HealthStart Screening and Related Procedure

PRIOR AUTHORIZATION FORMS

_____	MC-12(A)	Transportation Prior Authorization
_____	FD-06	Prior Authorization for Rehabilitative Services
_____	FD-07	Request for Authorization for Mental Health Services and/or Mental Health Rehabilitation Services
_____	FD-07A	Prior Authorization - Supplemental Information
_____	FD-287	Home Apnea Monitor Certification
_____	FD-352	Prior Authorization for Specialized Group Foster Home (ACCAP)
_____	FD-354	Medical Supplies and Equipment Prior Authorization
_____	FD-356	Request for Prior Authorization for Podiatric Services
_____	FD-357	Request for Prior Authorization for Prosthetic and Orthotic Services
_____	FD-358	Request for Prior Authorization for Vision Care
_____	FD-359	Request for Prior Authorization for Pharmaceutical Service
_____	FD-365	Prior Authorization Request

Attachment Forms

_____	FD-10	Definition and Criteria for Assessing Handicapping Malocclusion Permanent Dentition
_____	FD-36	Audiologic and Hearing Aid Examinations
_____	FD-179	Physician Certification (Abortion)
_____	FD-189	Hysterectomy Receipt of Information Form
_____	FD-244	Hearing Aid Follow-Up Report
_____	FD-257	Nursing Facility Hearing Aid Screening
_____	7473-M ED	Sterilization Consent Form

Miscellaneous Forms

_____	FD-197	Patient Certification Form
_____	FD-266	Medicaid Second Opinion Program Brochure
_____	FD-999	Adjustment Request Form-NJMMIS Medicaid
_____	FD-998	Medicaid Claim Inquiry/Response Form
_____	Reprint:	"Handicapping Malocclusion Assessment to Establish Treatment Priority"

* These forms are a combination Prior Authorization and claim form.

Return Completed form to: Unisys, P.O. Box 4804, Trenton, NJ 08650-4804

