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

NEWSLETTER

Volume 13 No. 23 **May 2003**

TO: Providers of Community Adult Mental Health Rehabilitation Services– **For Action**
Health Maintenance Organizations - **For Information Only**

SUBJECT: **Community Adult Mental Health Rehabilitation Services Provided to Medicaid/NJ FamilyCare – Plan A Beneficiaries**

EFFECTIVE: For claims with dates of service on or after **July 1, 2002**

PURPOSE: The purpose of the Newsletter is to inform providers of the implementation of Community Adult Mental Health Rehabilitation Services as a Medicaid/NJ FamilyCare – Plan A reimbursable service and to communicate the policies and procedures related to this service that the provider must follow when requesting reimbursement.

BACKGROUND: Community Adult Mental Health Rehabilitation (AMHR) Services are provided in/by any community residence programs (except supportive housing as defined in N.J.A.C. 10:37A) that are licensed by, and under contract with, the Division of Mental Health Services (DMHS). These residences include group homes and supervised apartments operated by appropriately trained staff, and private homes with trained, DMHS contracted sponsoring families. The services are provided in accordance with requirements of N.J.A.C. 10:37A, Community Residences for Mentally Ill Adults.

Traditionally, the Medicaid/NJ FamilyCare program has provided reimbursement for discrete mental health personal care assistant (PCA) services rendered to Medicaid/NJ FamilyCare–Plan A beneficiaries who reside in the facilities listed above. Reimbursement for all other services provided and any other operating costs had been provided through contracts with the DMHS.

This Initiative, which is a cooperative effort between the Division of Medical Assistance and Health Services (Medicaid/NJ FamilyCare) and DMHS, implements AMHR services. This change includes more services than PCA/MH and more accurately describes the actual level of mental health rehabilitative services provided, allowing for a more appropriate level of federal reimbursement.

Under this change, AMHR services now include, but are not limited to, assessment and development of a comprehensive service plan, and implementation of the service plan through individual services coordination, training in daily living skills and supportive counseling. Discrete mental health PCA services have been subsumed into this definition; therefore separate reimbursement for mental health PCA services will no longer be provided for these types of residential programs. The Medicaid/NJ FamilyCare reimbursement rates for AMHR services have been developed to include all mental health rehabilitation services provided by the residential program.

ACTION: Effective for dates of service on or after **July 1, 2002**, providers who provide services in group homes, supervised apartments or contracted private homes (Level A+, A, B, C and D), licensed in accordance with N.J.A.C. 10:37A, shall seek Medicaid/NJ FamilyCare reimbursement for community AMHR services, based on the level of service rendered, as allowable by the provider's license and DMHS contract. The DMHS will continue to license the providers and will certify to the Medicaid/NJ FamilyCare program the level of care and the number of beds for which each provider is licensed to seek reimbursement.

LEVELS OF SERVICE

Level A+ means community mental health rehabilitation services available in the community residence, or in a community setting, 24 hours per day, delivered by the provider. Reimbursement shall be provided on a per diem basis.

Level A means community mental health rehabilitation services available in the community residence or in a community setting at least 12 hours per day, but less than 24 hours per day, delivered by the provider. Reimbursement shall be provided on a per diem basis.

Level B means community mental health rehabilitation services available in the community residence, or in a community setting, at least 4 hours per day, but less than 12 hours per day, delivered by the provider. Reimbursement shall be provided on a per diem basis for AMHR Level B services rendered in a group home setting. Reimbursement shall be provided for complete quarter-hour units of service for AMHR services rendered in a supervised apartment setting.

Level C means community mental health rehabilitation services provided in the community residence or in a community setting a minimum of 1 hour per week, delivered by the provider. Reimbursement shall be provided for complete quarter-hour units of service.

Level D means community mental health rehabilitation services available in the community residence, in residences not to exceed five residents, or in a community setting, 24 hours per day, delivered by the provider. Note: In N.J.A.C. 10:37A, the Level D homes are referred to as "Family Care Homes."

Providers shall bill for the lesser of the contracted level of care of the program or the level of service provided to the resident. For example: If a resident is in a Level A+ group home and his or her nursing assessment or reassessment indicates that the resident has improved and is now able to be maintained receiving Level A services, the provider shall provide and request reimbursement for, Level A services, until such time as the resident can be transferred to a Level A residence.

BENEFICIARY ELIGIBILITY

Medicaid and NJ FamilyCare–Plan A beneficiaries are eligible to receive community AMHR services. Eligible beneficiaries may be identified by a NJ Medicaid/NJ FamilyCare Eligibility Identification Card. The card will indicate the beneficiary's name, plan designation and his or her 12-digit identification number. Providers should make a copy of the beneficiary's identification card each month to confirm continued eligibility. Providers can confirm a beneficiary's eligibility by telephone inquiry to the Recipient Eligibility Verification System (REVS) at Unisys at 1-800-676-6562 or by accessing the eligibility file through the use of a Medicaid Eligibility Verification System (MEVS) vendor.

NJ FamilyCare beneficiaries enrolled in Plans B, C, D, G, H and I are not eligible to receive community AMHR services.

PROVIDER ENROLLMENT

Community Residences for Mentally Ill Adults that are licensed by, and under contract with, the Division of Mental Health Services (DMHS) in accordance with N.J.A.C. 10:37A, are required to enroll as Adult Mental Health Rehabilitation providers in the NJ Medicaid/NJ FamilyCare program. Providers who were previously enrolled as Mental Health PCA providers are required to re-enroll as this new provider type and will be issued a new provider number for seeking reimbursement for these services under this Initiative. This re-enrollment process may take several months to fully complete and providers will be notified individually as their applications are processed and the new provider numbers are issued.

Until such time as the provider receives notification of the new provider number, reimbursement requests for AMHR services should be submitted using the provider's current Mental Health PCA Medicaid/NJ FamilyCare provider number.

NURSING ASSESSMENTS

All beneficiaries shall receive a comprehensive nursing assessment, which shall include a justification for the services and a recommendation for the appropriate level of care, within 14 days of admission. This assessment is in addition to the comprehensive intake assessment already required. This comprehensive nursing assessment is to be used in conjunction with the comprehensive intake assessment to develop the comprehensive service plan (CSP) required in N.J.A.C. 10:37A; therefore, a separate nursing care plan is no longer required. A Registered Nurse or higher level of nursing professional must complete all comprehensive nursing assessments.

Each case shall be reviewed a minimum of every 60 days to assure that services are being delivered in accordance with the comprehensive service plan. A Registered Nurse or higher level shall complete this review

Comprehensive nursing reassessments are to be completed on at least an annual basis for all residents of the program and shall include a justification for a continuation of the services and a recommendation for the appropriate level of care. Nursing reassessments **MUST** be completed upon a significant change (positive or negative) in the condition of a beneficiary, which may warrant a change, permanent or temporary, in the level of care provided. A Registered Nurse or higher level of nursing professional must complete all comprehensive nursing reassessments.

RECORDKEEPING REQUIREMENTS

Providers shall be responsible for maintaining sufficient records to document the services provided to Medicaid/NJ FamilyCare—Plan A beneficiaries, consistent with the needs of the resident and the level of care of the facility.

Examples of mental health rehabilitation services include, but are not limited to, personal care skill development, psychiatric illness self management, substance abuse management, personal health maintenance, social functioning skill development, community living skill development,

This documentation shall be maintained by the provider, in the format most convenient for the provider that contains the required information, and shall be available for review by the DMHS or other authorized State agency upon request. An example of one type of format is attached to this newsletter. This is not a required form; this is simply a suggestion of one way in which to organize and record the required information.

1. Recordkeeping for adult mental health rehabilitation services shall include clinical records and reports for each individual beneficiary. These reports must cover the medical, nursing, social and health related care rendered to the beneficiary in accordance with accepted professional standards.

2. At a minimum, the provider shall maintain the following documentation in support of all claims for payment:

a. The name of the beneficiary;

b. The date(s) service(s) were provided;

c. The activity or activities provided as included in the plan of care;

d. The name of the residential program providing the service, the name and title of the individual rendering the service and the specific location that the service was provided; and

e. Appropriate service documentation based on unit of service:

- ✓ Providers of services reimbursed on a per diem basis documentation must include a daily census of the residence and documentation of staffing levels consistent with the level of care.

- ✓ Providers of services reimbursed for quarter-hour units of service documentation must include the time of arrival and departure of the staff member(s), the total amount of time Medicaid/NJ FamilyCare—Plan A-reimbursable services were provided, a brief description of the services provided, and the names of the resident(s) receiving the services.

3. The Division of Mental Health Services Bureau of Licensing will monitor documentation as part of the triennial licensing review process.

4. The annual DMHS housing inspections specific to the environment will continue.

5. All records shall be made available, upon request, to the Department of Human Services or any of the Department's authorized agents, including, but not limited to, the Division of Mental Health Service or the Division of Medical Assistance and Health Services.

REIMBURSEMENT

The rates shall be all-inclusive and shall be based on the range of mental health rehabilitation services included in the service definition of the level of services provided to the beneficiary. The services included in the calculation of the reimbursement rate shall only be the mental health rehabilitative services provided to the individual resident, as included in their comprehensive service plan.

The fee shall not include non-treatment and/or non-rehabilitation-related services, including, but not limited to, room and board, recreational and vocational services.

HCPCS Procedure Codes and Maximum Fee Allowances

HCPCS CODE	MOD	DEFINITION	MAXIMUM FEE ALLOWANCE
Z7333		Adult MH Rehab. Svcs. Level A+ Group Home (per diem)	$164.00
Z7333	52	Adult MH Rehab. Svcs. Level A+ Supervised Apartment (per diem)	$164.00
Z7334		Adult MH Rehab. Svcs. Level A Group Home (per diem)	$131.00
Z7334	52	Adult MH Rehab. Svcs. Level A Supervised Apartment (per diem)	$66.00
Z7335		Adult MH Rehab. Svcs. Level B Group Home (per diem)	$102.00
Z7335	52	Adult MH Rehab. Svcs. Level B Supervised Apartment (per quarter-hour)	$3.75 ($15.00/hour)
Z7336		Adult MH Rehab. Svcs. Level C Group Home (per quarter-hour)	$3.75 ($15.00/hour)
Z7336	52	Adult MH Rehab. Svcs. Level C Supervised Apartment (per quarter-hour)	$3.75 ($15.00/hour)
Z7337		Adult MH Rehab. Svcs. Level D (Family Care) Home (per diem)	$40.00

Medicaid/NJ FamilyCare—Plan A reimbursement will not be provided for Mental Health PCA services and Community AMHR Services provided on the same date of service for the same Medicaid/NJ FamilyCare—Plan A beneficiary. Medical or physical PCA services rendered to these beneficiaries will be reimbursed if all other

requirements for those services are met. Community AMHR reimbursement includes payment for mental health PCA services.

Medicaid/NJ FamilyCare reimbursement will not be provided for Programs of Assertive Community Treatment (PACT) Services and Community AMHR Services provided on the same date of service for the same Medicaid/NJ FamilyCare beneficiary.

Medicaid/NJ FamilyCare reimbursement will be provided for mental health case management services including, but not limited to, adult targeted case management or Care Management Organization (CMO) services rendered to Medicaid/NJ FamilyCare beneficiaries enrolled in any level of community AMHR services, if the services are rendered in accordance with the requirements of N.J.A.C. 10:73, Case Management Services.

BILLING PROCEDURES

To ensure appropriate reimbursement is received, providers must bill for the appropriate level of service provided using the Centers for Medicare & Medicaid Services Healthcare Procedure Coding System (HCPCS) codes listed above (on page 5), ***not*** the HCPCS procedure codes formerly used to claim reimbursement for mental health personal care services.

Providers must use their current Mental Health PCA provider number and the new HCPCS procedure codes to ensure appropriate reimbursement is received.

Reimbursement for PCA Codes and AMHR codes will not be provided for the same beneficiary on the same date of service.

In addition to the use of the appropriate HCPCS procedure code, providers will be required to enter the applicable diagnosis code(s) on the CMS 1500 for each beneficiary. These codes can be found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Providers must use the CMS 1500 claim form (formerly the HCFA 1500) when seeking reimbursement. Examples of properly completed claim forms are attached to this Newsletter.

PROVIDERS WHO BILL PER DIEM RATES
(LEVELS A+, A, B GROUP HOMES, AND D)

1. Per diem providers shall seek Medicaid/NJ FamilyCare reimbursement on dates that the beneficiary is listed as being a resident of the home or apartment, and is physically present for any portion of the entire 24-hour period starting and ending at midnight.

2. If a resident is out of the home for a complete 24-hour period, that is, the resident was not in the residence for the entire 24 hour period starting and ending at midnight, providers shall not seek reimbursement for that day.

3. Per diem providers may bill for days that the resident was present for part of the day and then left, *if the resident is reasonably expected to return either later that day, or at a later date.*

For example: A resident leaves for a visit with family members who live out of town for vacation and is expected to return to the group home in five days. The provider can request Medicaid/NJ FamilyCare reimbursement for the day the resident leaves for the trip *and* the day the resident returns from the trip. The provider cannot request Medicaid/NJ FamilyCare reimbursement for the days the resident was not in the residence for the entire 24 hour period starting and ending at midnight.

07/12/02 – 07/31/02	20 days of service provided	(20 units of service)
08/01/02 – 08/31/02	31 days of service	(31 units of service)
09/01/02 – 09/12/02	12 days of service	(12 units of service)
09/18/02 – 09/30/02	12 days of service	(12 units of service)

This example shows that there was a break in service from 09/13/02 – 09/17/02 and, therefore, these days are not eligible for reimbursement through the Medicaid/NJ FamilyCare program.

4. Per diem providers may bill for consecutive dates of service on the same line, but shall not include dates from more than one calendar month on the same line.

5. Per diem providers will be reimbursed on the day the resident is admitted, but shall not request reimbursement on the date a resident is discharged.

- Discharge is defined as any date that the resident leaves the facility and is not reasonably expected to return; for example, if the resident is transferred to another living arrangement.

6. Providers will continue to be reimbursed for non-Medicaid/NJ FamilyCare-reimbursable services under their individual DMHS contracts, such as room and board costs.

****No request for reimbursement should be made to Medicaid/NJ FamilyCare for days that the individual did not receive mental health rehabilitation services****

PROVIDERS WHO BILL IN QUARTER-HOUR UNITS OF SERVICE
(LEVEL B SUPERVISED APARTMENTS AND LEVEL C)

1. A quarter-hour unit of service is defined as 15 consecutive minutes of service. Non-consecutive shorter time periods may not be added together to total 15 minutes.

2. Providers should request reimbursement for each day services are provided to each individual resident.

3. Providers need to complete a separate claim line on the CMS 1500 for each day that services were provided and indicate the total number of service units provided on each day.

For example:

07/10/02	1:00-1:15p.m.	(1 unit of service)	
07/11/02	2:00-2:23p.m.	(1 unit of service)	
07/12/02	12:00-12:30p.m. 5:00-5:35p.m.	(2 units of service) (2 units of service)	(total of 4 units of service)
07/15/02	8:00-8:45a.m. 9:00-9:45p.m.	(3 units of service) (3 units of services	(total of 6 units of service)
07/20/02	11:00-11:30p.m.	(2 units of service)	

4. Exact time frames are included here for illustrative purposes and are not indicated on the CMS 1500 claim form. However, documentation of this information is required to be in the records maintained by the provider in support of the claim.

5. Multiple quarter hour units of service do not need to be consecutive; however, all single units of service must total 15 consecutive minutes. Providers shall not round up to complete a unit of service.

6. A separate CMS 1500 claim form must be completed for each resident, whether services were provided individually or in a small group setting.

GENERAL CLAIM COMPLETION GUIDELINES

***** Use no more than six claim service detail lines on each form.

* Total each claim form as an independent submission. Total Charge (Item 28), Amount Paid (Item 29) and Balance Due (Item 30) may not be continued from one claim form to an additional claim form.

* Print the information legibly, completely, and correctly with a typewriter, printer, or ballpoint pen (black ink preferably).

* Enter all dates in month, day, and year sequence (MMDDYY). For example, September 10, 1994 is entered as 091094.

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

* Verify the accuracy of all information before submitting the claim.

* Forms that are not legible or that cannot be imaged because the print is too light will be returned to the provider.

Submit completed CMS-1500 claim forms to:

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

Billing can either be done directly by the provider or through a billing agent that the provider has contracted with. Electronic billing procedures and direct deposit of reimbursement checks are also available. Providers who wish to take advantage of these options should contact Unisys Provider Services at 1-800-776-6334 for the necessary instructions.

Samples of completed CMS 1500 claim forms and step-by-step completion instructions are attached to this newsletter. A complete Fiscal Agent Billing Supplement will be sent to providers under separate cover, as part of the provider manual.

If you have any questions regarding Medicaid/NJ FamilyCare documentation requirements, please contact the Office of Utilization Management, Mental Health Unit, at 609-588-2721.

If you have any questions regarding documentation requirements for the Division of Mental Health Services, please contact Alan Carmy of the DMHS Bureau of Licensing at 609-341-3332.

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

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

SAMPLE

SERVICE DOCUMENTATION GRID

Maple Street Group Home

Resident Name:_____

Week of:_____**(Sunday to Saturday)**

Goal	Activity	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
	PERSONAL CARE SKILL DEVELOPMENT • Personal Hygiene • Food Preparation, Acquisition and Nutrition • Household Maintenance Skills							
	PSYCHIATRIC ILLNESS SELF MANAGEMENT SKILL DEVELOPMENT • Symptom Risk Factor Recognition • Self Management of Behavior • Relapse Planning Strategy Development • Medication Education • Problem Solving/Coping Strategy Development							
	SUBSTANCE ABUSE MANAGEMENT • Management of Chemical Abuse Issues							
	HEALTH MAINTENANCE • Instruction in proper health maintenance							
	SOCIAL FUNCTIONING SKILL DEVELOPMENT • Interpersonal relationship development							
	COMMUNITY LIVING SKILL DEVELOPMENT • Utilization of community resources • Benefit acquisition • Daily living skill development activities • Work readiness skill development							
15 MINUTE UNITS OF SERVICE (Level B apartments and all Level C programs) STAFF ARRIVAL & DEPARTURE TIMES & INITIALS								
• Record Total Amount of Time Services Provided								
• Record Total Units of Service (Consecutive 15 minute periods of time)								
PER DIEM UNITS OF SERVICE (Level A, Level B group homes, Level D) STAFF WHO DELIVERED SERVICE AND RECORDED INFORMATION – INITIAL DAILY								

THE ACTIVITIES ABOVE ARE INCLUDED FOR ILLUSTRATIVE PURPOSES ONLY. ACTUAL ACTIVITIES SHOULD BE DRIVEN BY THE COMPREHENSIVE SERVICE PLAN DEVELOPED FOR EACH INDIVIDUAL RESIDENT

DAILY NOTES
(as needed)

RECORD OF OFF-SITE APPOINTMENTS/TRIPS

WEEKLY PROGRESS NOTE
(required by DMHS regulation)

ADULT MENTAL HEALTH REHABILITATION SERVICES

CMS 1500 CLAIM FORM INSTRUCTIONS

MAY 2003

ADULT MENTAL HEALTH REHABILITATION SERVICES

GENERAL CLAIM COMPLETION GUIDELINES

* Use no more than six claim service detail lines on each form.

* Total each claim form as an independent submission. Total Charge (Item 28), Amount Paid (Item 29) and Balance Due (Item 30) may not be continued from one claim form to an additional claim form.

* Print the information legibly, completely, and correctly with a typewriter, printer, or ballpoint pen (black ink preferably).

* Enter all dates in month, day, and year sequence (MMDDYY). For example, September 10, 1994 is entered as 091094.

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

* Verify the accuracy of all information before submitting the claim.

* Forms that are not legible or that cannot be imaged because the print is too light will be returned to the provider.

Submit completed CMS-1500 claim forms to:

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

DO NOT STAPLE IN THIS AREA

[redacted]

COMMUNITY ADULT MENTAL HEALTH REHABILITATION SERVICES
PER DIEM UNIT OF SERVICE
SAMPLE

PICA

HEALTH INSURANCE CLAIM FORM

ICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)	123456789012
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ALDEN JOHN Q.	3. PATIENT'S BIRTH DATE (MM DD YY) 06 23 57 SEX M ☒ F ☐
5. PATIENT'S ADDRESS (No., Street) 45 MAIN STREET	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: TOWNSVILLE — STATE: NJ	8. PATIENT STATUS Single ☒ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE: 01234 — TELEPHONE (Include Area Code): (609) 555-4321	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (INCLUDE AREA CODE) ( )
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH (MM DD YY)	SEX M ☐ F ☐
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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 (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM DD YY)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM 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 (MM DD YY) FROM TO (MM DD YY)
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. | . 2958 3. | .		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A: DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B: Place of Service	C: Type of Service	D: PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS	MODIFIER	E: DIAGNOSIS CODE	F: $ CHARGES	G: DAYS OR UNITS	H: EPSDT Family Plan	I: EMG	J: COB	K: RESERVED FOR LOCAL USE
07 12 02	07 31 02	99	99	Z7334	52	1	1254 00	19				
08 01 02	08 31 02	99	99	Z7334	52	1	2046 00	31				

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO. 123456	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE 3300 00	29. AMOUNT PAID 0 00	30. BALANCE DUE 3300 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.)	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 #
Original Signature SIGNED DATE		LEVEL A SUPV. APT. 45 MAIN STREET TOWNSVILLE NJ 01234 PIN # GRP # 1234567

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
REORDER FROM STANDARD REGISTER FORM NO. HC0901B-1

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 **FORM RRB-1500**

COMMUNITY ADULT MENTAL HEALTH REHABILITATION SERVICES

15 MINUTE UNIT OF SERVICE

SAMPLE

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

ICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234 567890 12	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ALDEN JOHN Q.	3. PATIENT'S BIRTH DATE MM DD YY / SEX 06 23 57 M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 45 MAIN STREET	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: TOWNSVILLE / STATE: NJ	8. PATIENT STATUS Single ☒ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE: 01234 / TELEPHONE (Include Area Code): (609) 555-4321		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) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☒ NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ 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? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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		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 MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17A. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. | . 2958 3. | .		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
07	12	02	07	12	02	99	99	Z7336		1	15	00	4				
07	15	02	07	15	02	99	99	Z7336		1	22	50	6				
07	24	02	07	24	02	99	99	Z7336		1	7	50	2				

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO. 123456	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE 45 00	29. AMOUNT PAID 0 00	30. BALANCE DUE 45 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.) *Original Signature* SIGNED DATE	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 # LEVEL C GROUP HOME 45 MAIN STREET TOWNSVILLE NJ 01234 PIN # GRP # 1234567		

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

DATA ELEMENT: Coverage indicator

Definition:

Instruction: Place an "X" in the box for Medicaid if billing for services provided to a Medicaid/NJ FamilyCare beneficiary.

Field Characteristics: Alpha
1 position

Values:

Notes:

CLAIM TYPE (S): 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 eligibility 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:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): 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, 1941 is entered as 091041. Enter an "X" in the appropriate box that identifies the sex of the beneficiary.

Field Characteristics:	**Birthdate**	**Sex**
	Numeric 6 positions	Alpha 1 position

Values:

Notes:

CLAIM TYPE (S): R

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 4

DATA ELEMENT: Insured's Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 5

DATA ELEMENT: Patient's Address

Definition: The location of the patient's residence.

Instruction: Enter the patient's complete address.

Field Characteristics:

Values:

Notes: For mental health rehabilitation services provided in group homes or other residential facilities, enter the address of the facility where the beneficiary is currently residing.

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 6

DATA ELEMENT: Patient Relationship to Insured

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 7

DATA ELEMENT: Insured's Address

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 8

DATA ELEMENT: Patient Status

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 9

DATA ELEMENT: Other Insured's Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 9c

DATA ELEMENT: Employer's Name or School Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 9d

DATA ELEMENT: Insurance Plan Name or Program Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): OR

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 this billing supplement.
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.

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 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:

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 11a

DATA ELEMENT: Insured's Date of Birth/Sex

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 11b

DATA ELEMENT: Employer's Name or School Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 11c

DATA ELEMENT: Insurance Plan Name or Program Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

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.

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **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 "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.

CLAIM TYPE (S): R

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 13

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

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 14

DATA ELEMENT: Date of Current Illness

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 15

DATA ELEMENT: If Patient Has Had Same or Similar Illness

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 16

DATA ELEMENT: Dates Patient Unable to Work in Current Occupation

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 17a

DATA ELEMENT: I.D. Number of Referring Physician

Definition:

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

Field Characteristics: Numeric
7 positions

Values:

Notes: If the referring physician/practitioner is a non-participant in the NJ Medicaid/NJ FamilyCare Program, enter seven fives (5555555) for out-of-state providers or seven sixes (6666666) for in-state providers.

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 18

DATA ELEMENT: Hospitalization Dates Related To Current Services

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 19

DATA ELEMENT: Reserved For Local Use

Definition:

Instruction:

Field Characteristics: Numeric
10 positions

Values:

Notes:

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 20

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:

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 21

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.

CLAIM TYPE (S): R

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 22

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

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 23

DATA ELEMENT: Prior Authorization Number

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

Instruction: If applicable, enter the Prior Authorization number for this service.

Field Characteristics: Numeric
10 positions

Values:

Notes: Prior Authorization is not required for Community Adult Mental Health Rehabilitation Services

CLAIM TYPE (S): NR

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

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:

Mental health rehabilitative service providers shall bill the date of admission but not the date of discharge. Providers may bill for consecutive dates of service on the same line, but shall not span dates from month to month.

Providers who bill per diem units of service shall not seek reimbursement on dates that the beneficiary is listed as being a resident of the home or apartment, but is not physically present for the 24-hour period starting and ending at midnight.

For example:

07/12/02 – 07/31/02	20 days of service provided	(20 units of service)
08/01/02 – 08/31/02	31 days of service	(31 units of service)
09/01/02 – 09/12/02	12 days of service	(12 units of service)
09/18/02 – 09/30/02	12 days of service	(12 units of service)

Providers who bill in quarter-hour (15 minute) increments must complete a separate claim line on the CMS 1500 for each day that services were provided and indicate the total number of service units provided on that day.

For example:

07/12/02 – 07/12/02	1 hour of services provided	(4 units of service)
07/15/02 – 07/15/02	90 minutes of services provided	(6 units of service)
07/20/02 – 07/20/02	30 minutes of service provided	(2 units of service)

CLAIM TYPE (S): R

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

DATA ELEMENT: Place of Service

Definition: The place where services were performed.

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

For mental health rehabilitation services provided in residential settings, enter code number 99.

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
71- State or Local Public Health Clinic
81- Independent Lab
99- Other

CLAIM TYPE (S): R

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.
For mental health rehabilitation services, use 99.

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

CLAIM TYPE (S): R

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 procedures covered by Medicaid/NJ FamilyCare.

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

Field Characteristics: Alpha-numeric
9 positions

Values:

Notes:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): R

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

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: Do not use decimal points or dollar signs.

CLAIM TYPE (S): R

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

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: Multiple units may be billed on a single claim line.

- Providers using "per diem" units of services can bill for consecutive dates of service on the same line, but shall not span dates from month to month. The dates of service may not span dates that the beneficiary was not physically present for the 24-hour period starting and ending at midnight.
- Providers who bill in quarter-hour (15 minute) increments must complete a separate claim line on the CMS 1500 for each day that services were provided and indicate the total number of service units provided on that day. The total amount of units of service billed not exceed the maximum amount of service for the specific level of care provided. For example: A Level B Supervised Apartment is required to provide between 4 and 12 hours of service per day, therefore, the billable units not exceed 48 per day.

CLAIM TYPE (S): R

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

DATA ELEMENT: EPSDT/Family Planning

Definition:

Instruction: If the service is an EPSDT/Family Planning referral enter the appropriate value.

Field Characteristics: 1 position

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

Notes:

CLAIM TYPE (S): OR

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

DATA ELEMENT: EMG

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): NR

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

DATA ELEMENT: COB

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): 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, then indicate the servicing provider number in form locator 33 PIN #.

Field Characteristics: Numeric
7 positions

Values:

Notes: This is not required for adult mental health residential services

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 25

DATA ELEMENT: Federal Tax ID Number

Definition: Federal Tax ID Number.

Instruction: Enter the Federal Tax ID Number.

Field Characteristics: Numeric
9 positions

Values:

Notes:

CLAIM TYPE (S): NR

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.

CLAIM TYPE (S): OR

EFFECTIVE: July 1, 1995 **FORM LOCATOR** 27

DATA ELEMENT: Accept Assignment?

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S): 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.

CLAIM TYPE (S): R

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:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): 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 form. Sign and date the form accordingly.

Field Characteristics: Alpha-numeric

Values:

Notes:

CLAIM TYPE (S): 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:

CLAIM TYPE (S): 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.

Field Characteristics: Alpha-numeric

Values:

Notes: This number must be entered to the right of GRP#

CLAIM TYPE (S): R