STATE OF NEW JERSEY

Department of Human Services
Division of Medical Assistance
and Health Services

NEW JERSEY
MEDICAID MANAGEMENT
INFORMATION SYSTEM
(NJMMIS)

PHYSICIAN SERVICES

Fiscal Agent Billing Supplement

gainwell

May 2025

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1.0 PREFACE

These billing instructions are for use by medical and health care service providers enrolled in New Jersey Medical and Pharmaceutical Assistance Programs. These billing instructions are not a legal description of all aspects of New Jersey's Medical Assistance Programs or Title XIX (Medicaid) and Title XXI (State Child Health Insurance Program, known in New Jersey as NJ FamilyCare Children's Program) of the Social Security Act. Should there be any conflict between material in these instructions and the pertinent laws, rules or regulations governing these programs, the latter take precedence. Each Provider Manual contains applicable references to the rules in the New Jersey Administrative Code.

The general information and procedures set forth in these instructions will enable providers to submit correct and accurate **fee-for-service** claims for services performed under the Medicaid/NJ FamilyCare Program and other applicable New Jersey Medical and Pharmaceutical Assistance Programs. Submission of error-free claims will result in prompt processing of claims for services rendered. Providers should become familiar with these billing instructions and should maintain this material in a special file for ready reference. These are also available on the Gainwell Technologies website: www.njmmis.com. Providers will be furnished with updated information related to these billing instructions as changes occur.

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2.0 INTRODUCTION

The New Jersey Medical Assistance and Health Services Act (P.L. 1968, c. 413, which is codified as N.J.S.A. 30:4D-1 et seq.) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. The Act and subsequent amendments provide legal authority for the administration of the New Jersey Medicaid/NJFC Program. Specific rules in the New Jersey Administrative Code provide detailed requirements for the providers. This Fiscal Agent Billing Supplement is incorporated by references into the New Jersey Administrative Code and has the same effect as the rules, that is, the force and effect of law.

The Medicaid/NJFC Program is administered by the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), through the Division's Central Office and through Medical Assistance Customer Centers (MACCs) located throughout the State of New Jersey.

The Pharmaceutical Assistance to the Aged and Disabled (PAAD) and Senior Gold Prescription Discount programs are administered by the Department of Human Services (DHS), Division of Aging Services (DoAS), through that Division's Central Office. DHS also oversees payment of healthcare services provided by the Division of Development Disabilities (DDD), the Division of Mental Health Services (DMHS), and the Division of Addiction Services (DAS).

The Department of Health (DOH) Division of HIV/AIDS, TB & STD Services oversees the AIDS Drug Distribution Program (ADDP) and the DOH also oversees health facility services and the Cystic Fibrosis Program.

The New Jersey DHS/DMAHS has contracted with Gainwell Technologies to be the fiscal agent for the New Jersey Medicaid/NJFC Program and to implement and operate the New Jersey Medicaid Management Information System (NJMMIS).

In addition, the NJMMIS is designed to process and pay claims as authorized for other Medical Assistance programs. The PAAD and CSOC Programs are examples. As used in this manual, the term "Medicaid/NJ FamilyCare" generally encompasses all medical assistance programs for which the NJMMIS processes claims. For further information pertaining to administration, refer to the New Jersey Administrative Code (N.J.A.C.) 10:49 (Administration) Chapter 1 of the Provider Manual for Medicaid/NJ FamilyCare and N.J.A.C. 8:83C for PAAD.

NOTE: The policies contained herein are applicable only to Medicaid/NJFC fee-for-service beneficiaries, or for services that are not the responsibility of managed care organizations participating in the Medicaid/NJFC Program.

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3.0 PROVIDER SERVICES

3.1 Functions

The Gainwell Technologies Provider Services Department provides comprehensive services to the provider community. The department is comprised of various units that include but may not be limited to: Provider Inquiry Communications Call Center, Correspondence, Enrollment, Fair Hearing, Provider Training, Second Opinion, and McKesson Clinical Inquiries.

All staff members of the Gainwell Technologies Provider Services Department are trained to assist providers with information needed to file complete and accurate claims, to research claims processing problems, and to comply with State and Federal rules, regulations and policies pertaining to the Medicaid/NJ FamilyCare, GA, ADDP, PAAD, Senior Gold, Medically Needy, and New Jersey Care programs and all other programs for which the NJMMIS is utilized to process and pay claims.

The Unit functions vary and may include but not be limited to the following:

- Responding to telephone/verbal inquires regarding Medicaid procedures and claim processing issues.
- Writing correspondence via mail or email.
- Performing On-site/Off-site billing training.
- Providing Medical providers the opportunity to submit a formal appeal of denied or disputed claims, which cannot be resolved through the normal claims re-submission process.
- Enrolling providers into the New Jersey Medicaid program.
- Maintaining, updating, and ensuring accuracy of the Provider Master File.
- Notifying Gainwell Technologies Publications of requests from providers for copies of Provider Manuals. (Gainwell Technologies Publications also ensures distribution of Newsletters, Alerts and other types of communication on behalf of NJ Medicaid/NJ FamilyCare programs.)

3.2 Provider Enrollment

In order for a provider to enroll in the NJ Medicaid/NJ Family Care Program, an enrollment application package must be completed. There are three (3) ways to obtain an application:

1. Call the Gainwell Technologies Provider Enrollment Unit at 609-588-6036

2. Write to: Gainwell Technologies
   Attention: Provider Enrollment Unit
   P.O. Box 4804
   Trenton, NJ 08650-4804

3. Visit Gainwell Technologies website at www.njmmis.com to download the appropriate application package.

For options 1 and 2 above, the Enrollment Unit will mail an appropriate application packet to the requesting provider. When the application package is returned, all fields of the application **must** be completed, even if information requested is not applicable (if not applicable enter N/A*).* Providers also need to attach all necessary documentation (e.g., licensing board certification, CLIA #, etc.). Any required field not completed will cause the application process to stop and the package will be returned to the provider for correction.

Rules describing specific provider requirements can be accessed through the New Jersey Administrative Code link. The specific provider rules are contained in the chapter named for the services. Each provider must comply with the requirements in the Administrative Chapter (N.J.A.C. 10:49) as well as the specific chapter for this provider type.

After the provider application is accepted, the provider and/or non-billing provider is notified, in writing, of the assigned unique seven (7)-digit Medicaid Provider Identification Number (ID #). Only the participating providers will be issued a Provider Manual which includes the Administrative Code (10:49), the specific provider type instructions, the Fiscal Agent Billing Supplement detailing claims billing procedures, and applicable newsletters.

The provider is responsible for informing the Gainwell Technologies Provider Enrollment Unit of all updates and changes to his/her provider information in a timely fashion. This information includes all pertinent data originally submitted with the enrollment application. A confirmation of these changes will be mailed to the provider upon request.

If the provider application is not accepted, the applicant receives a written notification explaining the decision. If the applicant is found to be currently enrolled, e.g., an inactive provider who wants to be an active participant, the applicant is notified of the correct Medicaid/NJ Family Care provider ID# and the provider's existing record on the Provider Master file is re-activated. This also may include non-billing providers who may currently have an inactive Medicaid/NJ FamilyCare provider ID # in which the providers existing record on the Provider Master file is re-activated.

3.3 Provider Training

Gainwell Technologies provides training to the provider community for the purpose of educating and updating providers on current Medicaid/NJ Family Care claim/billing procedures, problems, and claim processing. The training sessions are held at the Gainwell Technologies NJMMIS site and other locations throughout the State of New Jersey.

Upo+n request, Gainwell Technologies provider training specialists will make scheduled visits to providers in their office for the purpose of educating and updating providers on current billing procedures. The Provider Trainers are not permitted to visit a provider's home. Training can only be provided at the business or authorized location.

3.4 Provider Communications (Provider Services) Call Center

The staff in the Provider Communications Unit, are trained to respond to specific questions from the provider community and their billing representatives relating to the completion of claims, allowable fees, claims payment status, beneficiary eligibility, program coverage, billing procedures, and any questions concerning drug codes, diagnosis codes, and procedure codes. All Call Center Specialists (Provider Services Representatives) have online access to the NJMMIS files for reference purposes.

The Call Center's telephone system operates through an Automatic Call Distribution (ACD) system. The ACD system is a switch feature that automatically distributes incoming calls to specific agents and allows the Call Center Specialists to answer calls in the order that they are received.

The Call Center Specialists are only allowed to assist callers who are valid NJ Medicaid providers. For security and HIPAA purposes, providers must have their Provider Medicaid ID # to obtain assistance.

3.4.1 Telephone Inquiries

The Provider Communications (Provider Services) Call Center telephone number is 1-800-776-6334. The Call Center is available to authorized providers who have a valid seven (7) digit New Jersey Medicaid ID # from 8:00 AM to 5:00 PM Eastern time, Monday through Friday; the Center is closed on weekends and State holidays.

In addition, the Recipient Eligibility Verification System (REVS) is available at 1-800-676-6562. The REVS line is a computer-generated voice response that offers three (3) different menu selections:

1. **Recipient Eligibility Verification System (REVS)**, touch-tone services.

2. **Second Opinion Referrals**, transfers to a Second Opinion Specialist.

3. **Remit Status**, touch-tone services, the caller is provided with the check amount for the current week and three (3) previous weeks.

The REVS line is available 24 hours a day, seven days a week to authorized providers who have entered a valid seven-digit NJ Medicaid provider ID #. The automated voice response system allows a maximum of 20 inquires per call.

Access to beneficiary eligibility information is also available through the Medicaid Eligibility Verification System (MEVS) and eMEVS. For more information on MEVS, refer to Section 4.7.

3.4.2 Written Inquiries

When a provider wants to correspond in writing to the Provider Services staff concerning claims processing or other matters, the provider may use an Inquiry/Response (I/R) form (a three-part form supplied by Gainwell Technologies [FD-998 (11-18)]) or a letter on his/her letterhead. In either case, a legible copy of the original claim and any supporting documentation must be attached to the provider's correspondence. When the I/R form is used, the provider submits two (2) parts (white & yellow) and retains the third part (pink copy). A copy of an I/R form and instructions for proper completion are included as Appendix A of these billing instructions. To request a supply of these forms, see Section 11. All written inquires are mailed to:

Gainwell Technologies
Attention: Provider Correspondence
P.O. Box 4801
Trenton, NJ 08650-4801

The Correspondence Specialist receives and responds to written inquiries from the Provider community within seven (7) days of receipt in the mailroom. The Correspondence Specialist is responsible for conducting research and developing content, as needed. All responses must be complete, accurate, and clearly address the issue(s) or question(s). The Correspondence Specialist responds to a written inquiry via a written letter.

Note: This avenue is for claims with issues. Providers should not use this forum for submission of claims or standard claims inquiries. Standard inquiries should be addressed by contacting the Gainwell Technologies Provider Services Call Center at 1-800-776-6334.

4.0 GENERAL BILLING INFORMATION

A claim is a bill that indicates a request for payment for a covered service provided to a Medicaid/NJ Family Care, PAAD, ADDP, Senior Gold, and/or any beneficiary of any program for which the NJMMIS is utilized to process and pay claims. The claim may be submitted hard copy (paper) or by means of an approved HIPAA 837 compliant Electronic Data Interchange (EDI) record.

This section contains general information for the submission of claims. Provider-specific instructions for the proper completion of a claim form and a sample claim form are included in **Section 6** of these billing instructions.

4.1 Beneficiary Eligibility Verification

A provider must verify beneficiary eligibility by examining the beneficiary's eligibility Health Benefits Identification (HBID) card each time a service is provided. It is important that providers check eligibility using the CCN from the HBID card or by using the 12-digit Medicaid number for all dates of services. Eligibility is usually established on a monthly basis by an appropriate agency, i.e., County Board of Social Services (CBOSS). **Gainwell Technologies does not determine eligibility**. Payment will not be made for a service provided during a period of beneficiary ineligibility. Exception to these payment restrictions is defined in Chapter II (General Provisions) of the Provider Manual.

If a beneficiary is unable to present HBID identification card, and the case number is known, the provider may verify eligibility by calling the REVS at 1-800-676-6562, (see Utilizing MEVS or eMVES, Section 3.4.1). **Calling REVS does not guarantee provider reimbursement because eligibility status may change before the claim is processed**. For additional information regarding claim payment for services provided in Good Faith, refer to the Administration Manual, N.J.A.C. 10:49, Chapter 1.

4.2 Health Benefits Identification Card (HBID)

New Jersey's FamilyCare/Medicaid program replaced the original paper cards with a monthly plastic identification card effective in June 2006. The HBID card was piloted in three counties originally and now exists in all counties in the State of NJ. The optical use of magnetic swipe technology allows providers quick and easy access to up-to-date client information.

Each family member will receive his or her own plastic identification card which is a permanent card. The card is for identification purposes only. Providers must verify eligibility before they provide services. The HBID card is an upgrade in technology and does not change existing policies.

Current eligibility verification methods, REVS, MEVS, and eMEVS can be utilized for verifying eligibility using the HBID card. The HBID card is client-specific and contains only a sixteen-digit card control number (CCN) and the client's name. There is no Medicaid identification number listed on the HBID card and no indication of eligibility. The HBID card does not indicate the level of covered services to which the client is entitled, therefore, providers must continue to check newsletters to ascertain the client's level of services.

The back of the card has a magnetic stripe similar to a credit card or ATM card. Providers have the option to purchase a swipe box (from a third-party vendor) to automatically enter the CCN into their preferred eligibility verification system.

The HBID card is mailed to the clients in an inactive status. The first provider who uses the card will activate the card and in most cases the activation process is transparent. The one exception is REVS, where the provider will be prompted for a date of birth to activate the card.

In instances where a client requires emergency medical services and the client does not have an HBID card, the client must give the provider a letter issued by the eligibility office (CWA, MACC office or State agency including DYFS, DFD, and DDD). This letter contains pertinent information which the provider will need to submit claims for that client. The letter also includes an expiration date when the letter will no longer serve as a substitute for an HBID card.

Questions related to the HBID program should be directed to the Gainwell Technologies HBID Unit, which is available to providers, clients and to County Welfare Agency staff and Statewide Eligibility Determination Agency through a toll-free number of 1-877-414-9251. This unit is also responsible for the issuance of all replacement HBID cards.

4.3 Provider Signature Requirements

All claims submitted hard copy for covered services must be personally signed by the provider or by an authorized representative. An authorized representative is an individual who completes the claim form. **Note: Only Original signatures are acceptable. No faxes, initials, stamps, or automated (machine-generated, copied) signatures are accepted.** For additional information regarding signature requirements, refer to the Administrative Manual N.J.A.C. 10:49, Chapter 1.

4.4 Claim Submission

Claims for services provided should be addressed to the proper P.O. Box; see **Section 6** of these billing instructions for the mailing addresses to be used for submission of claims. Upon receipt by Gainwell Technologies, claims will be screened for the presence of required data and legibility. Claims that pass the screening process will be imaged, assigned a unique fifteen (15) digit Internal Control Number (ICN), and the data will be entered into the NJMMIS for processing. Claims that fail the screening process will be returned to the submitting provider for correction and resubmission.

There are two instances in which an original claim will be returned to the Provider. First, if the claim is received after 01/01/2012 with no attachment, it will be returned to the Provider, please see Newsletter Volume 21 No. 25. Second would be if the claim(s) failed the screening processes. A Return To Provider (RTP) form will accompany the original claim form explaining why the claim is being returned. A sample of this form is included as **Appendix B** in these billing instructions. The provider must complete the missing or incomplete items, clarify any illegible items, and resubmit the original claim form to the appropriate P.O. Box for processing.

A claim will be returned to the provider for any of the following reasons:

- Detail information omitted entirely from claim
- Illegible copies
- Incorrect claim form
- Missing beneficiary signature or acceptable alternate
- Missing provider original signature
- Missing completion of Creation Date on UB-04 claim form
- Provider ID # missing or invalid
- Claims received after January 2012 without an attachment

4.5 Timeliness of Claim Submission

Policy regarding timely claim submission is cited in the Administration Manual N.J.A.C. 10:49, Chapter 1.

The first five (5) digits of the unique fifteen (15)-digit ICN # indicates the year and Julian date the claim was received for processing by Gainwell Technologies.

4.6 Medicare/Medicaid Claim Submission

Certain claims for payment of Medicare deductible and/or coinsurance may crossover from the Medicare Intermediary or Carrier to Gainwell Technologies. Other claims, which require additional, detailed information in order to be processed for payment, may be submitted hard copy or via Electronic Data Interchange (EDI), or Direct Data Entry (DDE), by the provider, to Gainwell Technologies. An Explanation of Benefits (EOB)

statement must accompany hard copy claims from the Medicare Intermediary or Carrier. **See Section 6** for specific detailed billing instructions.

4.7 Electronic Data Interchange (EDI)

EDI submission is a method by which claim information is submitted to Gainwell Technologies. All who submit claims electronically to New Jersey Medicaid must adhere to the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide and the New Jersey Medicaid Companion Guide requirements. See the HIPAA Companion Guide on the Gainwell Technologies website at www.njmmis.com for further information and instructions.

The Claims submission media is via the Internet, CD-Rom, or Cartridge. Advantages of EDI include:

- Speed: reduces processing time & expedites payment
- Accuracy: reduces errors
- Lower Cost: reduces paperwork

Information regarding EDI claims submission is available from the Provider Enrollment Unit as follows:

1. Calling: 609-588-6036

2. Writing: Gainwell Technologies
   Attention: Provider Enrollment Unit
   P.O. Box 4804
   Trenton, NJ 08650-4804

3. Website: www.njmmis.com

All technical questions regarding the transaction sets should be directed to the Gainwell Technologies EDI Unit at 609-588-6051.

4.8 Direct Data Entry

In 2010, DMAHS in conjunction with Gainwell Technologies, implemented a Direct Data Entry process which allows NJ Medicaid providers the opportunity to complete and submit claims via the njmmis.com website. In an effort to “Go Green” providers can choose this option for claims submission.

For Direct Data Entry claims, providers can enter claim data on electronic versions of the paper claim forms to reduce manual handling time. The initial phase of this process only supports claims without attachments or supporting documentation. The final phase will allow providers to complete direct data entry of claims that require some form of attachment.

Providers will require a Username and Password to access the secure area of the website to complete this claims submission process. Once in the secure area, providers will notice that the electronic forms are very similar to paper forms and data that is required for adjudication will be the only data that can be entered. Edits and validation of field information will occur to allow providers to correct errors immediately. Once the claim is submitted, the provider will be given an ICN for follow up on the status of the claim. It is important that providers document the ICN (reference number) for future follow up.

When accessing the Direct Data Entry application, it is best that providers utilize an Internet Explorer browser version of 7 or 8. Browser versions lower than 7 may encounter processing issues. If the providers' browser version is less than 7, then a message will display on the main page advising the provider that more compatible browser version is needed.

In light of the claims submitted through this process not having any direct manual handling, submissions received by 5:00 PM on Wednesdays will appear on the following weeks Remittance Advice.

4.9 Medicaid Eligibility Verification System (MEVS)

MEVS is a method for providers to obtain current on-line access, via a personal computer, to the beneficiary eligibility file at Gainwell Technologies for Medicaid/NJ Family Care, PAAD and Senior Gold beneficiaries. For a current list of MEVS vendors, contact the Provider Services Call Center at 1-800-776-6334, or log onto www.njmmis.com for a complete vendor listing.

When using MEVS, a provider enters a beneficiary's ID # or date of birth and a social security number for eligibility verification up to and including current month for date of service not older than one year from the date of the call.

The advantages of MEVS are:

- Most current eligibility information available on-line
- Less labor intensive than REVS
- Vendors can incorporate MEVS into new or existing claims software

MEVS does not guarantee provider reimbursement because eligibility status may change before the service is provided. For additional information regarding claim payment for services provided in Good Faith, refer to the Administration Manual, N.J.A. C. 10:49.

MEVS is available from 6 AM to 1 AM, 7 days a week.

4.10 Electronic Medicaid Eligibility Verification System (eMEVS)

eMEVS is a method for providers to obtain current on-line access, via a personal computer, to the beneficiary eligibility file at Gainwell Technologies for Medicaid/NJFC, PAAD and 56 beneficiaries.

This feature is accessible through the secure section of the NJMMIS website. A User Name and Password are required. The Provider Registration option on www.njmmis.com allows the provider to request secure access to this function.

4.11 Third Party Coverage Verification

DMAHS regulations require that a provider verify whether or not a beneficiary has other health insurance coverage. If the beneficiary is unable to present an identification card, and if the beneficiary Health Services Program (HSP) – (Medicaid/NJ Family Care) case number is known, the provider may verify other health insurance coverage by calling REVS. Reference **Section 3** of these billing instructions for REVS guidelines.

Services provided to Medicaid/NJ Family Care eligible individuals who are also covered by other health insurance must first be considered for payment by the other health insurance carriers. For exceptions to this rule, see the Administration Manual, N.J.A.C. 10:49 Chapter 1. In those situations in which payment is received from the health insurance carrier after the Medicaid/NJ Family Care Program has made payment, the provider must reimburse the Medicaid/NJ Family Care Program and not the beneficiary. Again, see the Administration Manual N.J.A.C. 10:49 Manual, Chapter 1 for specific instructions. Reimbursement must be made IMMEDIATELY. To initiate the process, providers must submit an Adjustment request form. See **Section 10** of these billing instructions for guidelines on submitting an adjustment request form. To view/download these forms, visit the Gainwell Technologies website at www.njmmis.com.

Corrections to the beneficiary's other health insurance coverage may be instituted by contacting the State TPL Unit at 609-826-4702.

4.12 Prior Authorization (PA)

DMAHS regulations mandate that certain services be authorized before those services are provided. Except in medical emergencies, see the Administration Manual N.J.A.C. 10:49, Chapter I, failure to obtain a required PA will result in the provider not being reimbursed for a service provided to an eligible beneficiary.

PA is not a guarantee of beneficiary eligibility and/or payment of services. The provider must verify that the beneficiary is eligible on the date of service.

For Out-of-State Hospital services effective October 1, 2008 prior authorization shall be required for inpatient and outpatient hospital services provided to a beneficiary outside the State of New Jersey. For additional information see Newsletter Volume 18 No. 12.

For a description of the services requiring PA and service limitations, see the General Provisions of the Provider Manual, Chapter II and the Medicaid/NJ Family Care, CBHS (formerly PFC/CSOCI) Newsletters concerning PA requirements. In addition, PA information can be found on the njmmis.com website.

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5.0 PRIOR AUTHORIZATIONS (PAs), CERTIFICATIONS, AND ATTACHMENTS

his section provides the information necessary to complete any PAs, Certifications, and/or Attachments, which may be required to support a Medicaid claim for service. For a description of services requiring a PA and service limitations, reference the Provider Manual, General Provisions, Chapter II.

NOTE: Forms that are not legible will be returned to the provider.

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5.1 Request For PA For Rehabilitative Services FD-06 (9/91)

The FD-06 (9/91) is the form used when a provider is requesting approval for rehabilitative services requiring a PA.

SAMPLE

Indicates the **Field #** on the FD-06 claim form.

1. RECIPIENT'S LAST NAME, FIRST NAME MI

EFFECTIVE: March 2010 **FORM LOCATOR** 1

DATA FIELD: Recipient's Last Name First Name MI R

Title of field.

Field is **required** to be completed.

What the DATA FIELD means.

Definition: Beneficiary's full name

How to fill out the DATA FIELD.

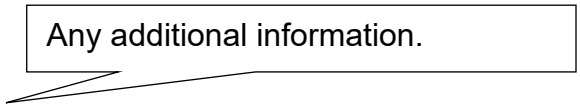
Instruction: Print or type the beneficiary's name EXACTLY as it is printed on their Medicaid Eligibility Identification card. Last name must be entered first.

The # of spaces in a particular field. Alpha, numeric or both.

Field Characteristics: Alpha

Numeric or alpha values in a particular field.

Values:



Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required or only if applicable.

R	= Field REQUIRED
NR	= Field NOT REQUIRED
OR	= Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

Prior Authorization Guidelines

- Print the information legibly, completely, and correctly.
- Print or type all dates using the month, day, and year (MM/DD/YY) format. For example, September 10, 2010 is entered 09/10/10.
- Provide all required information for every PA service detail line.
- Do not include a decimal point for dollar amounts. For example, enter 2500, not 25. Do not use the $ sign.
- Verify the accuracy of all information before submitting the appropriate form for PA.

PA requests for Rehabilitative Services are submitted to the beneficiary's respective MACC office.

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

PA# _____

REQUEST FOR PRIOR AUTHORIZATION FOR REHABILATIVE SERVICES

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address		Telephone Number
3. HSP (MEDICAID) Case No.	**4. Person No.**	**5. Date of Birth**	**6. Sex** ☐ Male ☐ Female	**City**	**State** / **ZIP Code**

7. PROVIDER OF SERVICE INFORMATION

Telephone Number

Medicaid Provider Number
(Enter only when not printed below)

Name and Address

8. MEDICAL INFORMATION AND THERAPY REQUESTED

A. TYPE OF THERAPY REQUESTED

( ) PHYSICAL ( ) OCCUPATIONAL ( ) SPEECH-LANGUAGE

B. HAS PATIENT PREVIOUSLY RECEIVED THERAPY FOR THIS CONDITION

( ) YES ( ) NO IF YES, WHEN

C. PERTINENT DIAGNOSIS

_____

_____

_____

D. DATE OF ONSET OF MEDICAL DX OF REHAB

E. PROGNOSIS _____

F. PROSTHECTIC OR ORTHOTIC DEVICE IN USE? ( ) YES ( ) NO

G. WAS PATIENT ABLE TO AMBULATE PRIOR TO ONSET OF PRESENT ILLNESS? ( ) YES ( ) NO

H. PRESENT FUNCTIONAL STATUS OR DEGREE OF INCAPACITY (CHECK APPROPRIATE SECTION)

( ) BEDRIDDEN ( ) CHAIRFAST ( ) AMBULATES WITH ASSISTANCE ( ) INDEPENDENT AMBULATION ( ) ABLE TO SUPPLY PERSONAL NEEDS

I. DOES PATIENTS MENTAL OR PHYSICAL STATUS PERMIT SUGGESTED THERAPY? ( ) YES ( ) NO

J. DESCRIBE SPECIFIC TREATMENT AND MODALITIES RECOMMENDED _____

_____

_____

K. FREQUENCY OF TREATMENT _____ TIMES PER WEEK _____ NUMBER OF WEEKS _____

L. ULTIMATE GOAL OF TREATMENT? _____

M. REAUTHORIZATION REQUEST (COMPLETE THIS SECTION ONLY IF THIS IS A REQUEST FOR CONTINUATION OF PREVIOUSLY AUTHORIZED THERAPY)
TO REQUEST REAUTHORIZATION DESCRIBE BELOW THE MEDICAL REASONS FOR REQUESTING ADDITIONAL REHABILITATIVE SERVICES

_____

_____

9. REQUESTED DATE(S)	10. AUTHORIZED DATE(S)	11. Reviewer ID / Review Date
From: _____ Thru: _____	From: _____ Thru: _____	

12. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 6 SERVICES) GRAY SHADED AREA FOR DIVISION USE ONLY

A.	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F.	G.	H. Description of Service	I. TOTAL FEE REQUESTED	J. FEE APPROVED	K.	L. Status

FD-06 (REV 9/91)

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EFFECTIVE: March 2010 **FORM LOCATOR** 1

DATA FIELD: Recipient's Last Name First Name MI | R |

Definition:

Instruction: Print or type the beneficiary's name EXACTLY as it is printed on the Health Benefits Identification Card. Last name must be entered first.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 2

DATA FIELD :	Recipient's Street Address	Telephone Number	R

Definition:

Instruction: Print or type the beneficiary's home address and telephone #, including area code.

Field Characteristics: Alpha/numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 3

DATA FIELD: HSP (MEDICAID) Case No. R

Definition: The ten (10) digit number that designates the beneficiary's Eligibility Identification number.

Instruction: Print or type the first ten (10) digits of the beneficiary's Medicaid Eligibility Identification number.

Field Characteristics: It is a 10 position, numeric field.

Values:

Notes: Providers can obtain the Beneficiary’s Medicaid Identification Number by verifying eligibility through eMEVS, MEVS, or REVS.

EFFECTIVE: March 2010 **FORM LOCATOR** 4

DATA FIELD: Person No. R

Definition: The two (2) digit number that designates the beneficiary's Eligibility Identification Person number.

Instruction: Print or type the last two (2) digits of the beneficiary's Eligibility Identification Person number.

Field Characteristics: It is a 2 position, numeric field.

Values:

Notes: Providers can obtain the Beneficiary’s Medicaid Identification Number by verifying eligibility through eMEVS, MEVS, or REVS.

EFFECTIVE: March 2010 **FORM LOCATOR** 5

DATA FIELD: Date of Birth

R

Definition: The date of birth of the beneficiary.

Instruction: Print or type the beneficiary's date of birth using the month, day, and year (MM/DD/YY) format. For example, September 10, 1981 is entered as 09/10/81.

Field Characteristics: It is a 6 position, numeric field.

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 6

DATA FIELD: Sex

R

Definition: The sex of the beneficiary.

Instruction: Check the box to indicate the beneficiary's sex.

Field Characteristics: It is a 1 position, alpha field.

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 7

DATA FIELD: PROVIDER OF SERVICE INFORMATION | R |

Definition: Provider's, Supplier's Billing Name, Address, Zip Code, and Phone Number.

Instruction: Print or type the provider's name, address, telephone number, and the seven (7)-digit Medicaid Provider ID #.

Field Characteristics: Alpha/Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 8A-M

DATA FIELD: MEDICAL INFORMATION AND THERAPY REQUESTED

R

Definition: The type of therapy requested and medical information.

Instruction: Complete questions A-L. Questions F and G are not required when requesting a PA for Speech-Language Therapy. Questions A-M are required when requesting re-authorization.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 9

DATA FIELD: REQUESTED DATE(S) R

Definition: The beginning and ending service date(s).

Instruction: Print or type the from and thru dates of service using the month, day, and year (MM/DD/YYYY) format.

Field Characteristics: It is a 16 position, alpha/numeric field.

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 10

DATA FIELD: AUTHORIZED DATE(S) NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 11

DATA FIELD: Reviewer ID Review Date NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12A

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12B

DATA FIELD: PROCEDURE & MODIFIER CODE REQUESTED

R

Definition: The procedure code is five (5) digits for all medical procedures covered by Medicaid. Use the two (2) digit modifier, if applicable.

Instruction: Print or type the five (5) digit HCPCS procedure code and two (2) digit modifier, if applicable, for each service provided.

Field Characteristics: It is a 7 position, alpha/numeric field.

Values:

Notes: A list of commonly used HCPCS codes is located in the Provider Manual.

EFFECTIVE: March 2010 **FORM LOCATOR** 12C

DATA FIELD: PROCEDURE CODE & MODIFIER CODE APPROVED

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12D

DATA FIELD: Units Requested

R

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

Instruction: Print or type the number of days or units of service.

Field Characteristics: It is a 4 position, numeric field.

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12E

DATA FIELD: Units Approved NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12F

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12G

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12H

DATA FIELD: Description of Service

R

Definition: The type of service(s) rendered.

Instruction: Print or type a description of service(s) to be rendered.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12l

DATA FIELD: TOTAL FEE REQUESTED

R

Definition: The usual and customary charge

Instruction: Print or type the provider's usual and customary charge for each service or procedure. This amount must reflect the total charge for all days or units of service for the detail line, including the cents positions for all dollar amounts. Do not use a decimal point. Do not use the $ sign. For example, enter 2500, **not** 25.00 or 25.

Field Characteristics: Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12J

DATA FIELD: FEE APPROVED NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12K

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12L

DATA FIELD: Status NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

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5.2 Request for PA for Mental Health (MH) Services (FD-07/07A)

This section provides form locator instructions for the completion of the following PA forms:

Request For PA For Mental Health Services and/or Mental Health Rehabilitation Services; form); and	**FD-07 (rev. 09/01)**
Request for PA Supplemental Information	**FD-07A (rev. 09/01)**

The FD-07 is a two (2)-ply form that must be used when a provider is requesting approval for MH Services requiring PA.

The FD-07A is a two (2)-ply form that provides supplemental information to the FD-07.

Providers submitting a PA request offered under the CBHS must submit the FD-07 (rev. 09/01) and the FD-07A (rev. 09/01) because CBHS services are not listed on the 1991 version.

Providers of non-CBHS services may continue to use the 1991 versions of the FD-07 and FD-07A until the supply is exhausted.

SAMPLE

Indicates the **Field #** on the FD-07 claim form.

1. BENEFICIARY'S LAST NAME, FIRST

EFFECTIVE: September 2001 **FORM LOCATOR** 1

DATA FIELD: Beneficiary's Last Name First Name MI R

Title of field.

Field is **required** to be completed.

What the DATA FIELD means.

Definition: Beneficiary's full name

How to fill out the DATA FIELD.

Instruction: Print or type the beneficiary's name EXACTLY as it appears on the Medicaid FamilyCare Eligibility Identification card. Last name, first name, middle initial.

The # of spaces in a particular field. Alpha, numeric or both.

Field Characteristics:

Numeric or alpha values in a particular field.

Values:

Any additional information.

Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required or only if applicable.

R	= Field REQUIRED
NR	= Field NOT REQUIRED
OR	= Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

Prior Authorization Guidelines

- The PA number, pre-printed on the upper right corner of the FD-07, must be appropriately transferred to the FD-07A and the submitted claim form by the provider. The required PA number is indicated on the notification notice distributed by Gainwell Technologies to each provider in response to each submitted PA request.

- Print or type the information legibly, completely, and correctly.

- Print or type all dates using the month, day, and year (MM/DD/YY) format. For example, September 10, 2001 is entered 09/10/01.

- Provide all required information for every PA service detail line.

- Include a decimal point and "cents" positions for all dollar amounts. For example, enter 25.00, not 25. Do not use a $ sign.

- Verify the accuracy of all information before submitting the appropriate form for a PA.

- Include the appropriate degree of clinical history and clinical status narrative to support the request for authorization.

- For any Special Programs, reference the newsletters in Section 5 of your Provider Manual.

NOTE: Print or type all information on both forms. Forms that are not legible will be returned to the provider.

PA requests for Mental Health Services are submitted as below:

PA requests for **Partial Care, Partial Hospitalization** or **Long Term Care for beneficiaries over age 21** should be submitted to the MACC Office for the address of the facility providing the service. Do not use the address of the beneficiary. If the provider provides services at more than one (1) location, use the address of the actual location where the services were provided to determine which MACC Office to submit the request to.

PA requests are submitted to:

Division of Medical Assistance and Health Services
Office of Utilization Management -- Mental Health Unit
Quakerbridge Plaza
P.O. 712 Mail Code #18
Trenton, NJ 08625-0712

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

REQUEST FOR PRIOR AUTHORIZATION FOR MENTAL HEALTH AND/OR MENTAL HEALTH REHABILITATION SERVICES

PA# 12_____

1. Beneficiary's Last Name	First Name	MI	2. Beneficiary's Street Address	Telephone Number

3. HSP (MEDICAID/NJ FamilyCare/CSOCI) Case No.	4. Person No.	5. Date of Birth	6. Sex ☐ Male ☐ Female	City	State	ZIP Code

7. Place of Service – Name and Address

8. PROVIDER OF SERVICE INFORMATION

Telephone Number _____

Provider Number _____ (Enter only when not printed below)

Name and Address

9. Brief Clinical History — **PLEASE ENTER INFORMATION AT #9A ON FORM FD-07A AND ATTACH**

10. Present Clinical Status (To support request) — **PLEASE ENTER INFORMATION AT #10A ON FORM FD-07A AND ATTACH**

11. Diagnosis and Code (Must Conform With ICD-9-CM) and Current Medications — **PLEASE ENTER INFORMATION AT #11A ON FORM FD-07A AND ATTACH**

12. Treatment Request	Frequency (Indicate Number)			Length of Session (Check)					
	Per Week	Per Month	Per Year	1 ½ Hour	1 hour	½ hour	1 Day	½ Day	Monthly
A. Psychotherapy, Individual									
B. Psychotherapy, Group									
C. Family Therapy									
D. Family Therapy/Conference									
E. Partial Care/Partial Hospitalization									
F. Medication Management									
G. Residential Services – CSOCI									
H. Behavioral Assistance – CSOCI									
I. Crisis Management Services – CSOCI									
J. Intensive In-Home – CSOCI									
K. Care Management Services – CSOCI									
L. Psychological Testing By Code Number									
M. Other (please specify)									

13. REQUESTED DATE(S) From: Thru:	14. AUTHORIZED DATE(S) From: Thru:	15. Reviewer ID Review Date

16. PRIOR AUTHORIZED SERVICES DETAIL — **GRAY SHADED AREAS ARE FOR DIVISION USE ONLY**

A.	B. REVENUE CODE OR PROCEDURE & MODIFIER CODE REQUESTED	C. REVENUE CODE OR PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F.	G.	H. Description of Service	I. TOTAL FEE REQUESTED	J. TOTAL FEE APPROVED	K.	L. Status

FD-07 (REV 09/01) **FISCAL AGENT COPY** Medicaid Part 1 of 2

Rev. May 2025

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EFFECTIVE: September, 2001 **FORM LOCATOR** 1

DATA FIELD: Beneficiary's Last Name First Name MI | R |

Definition:

Instruction: Print or type the beneficiary's name; last name must be entered first.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 2

DATA FIELD: Beneficiary's Street Address Telephone Number

R

Definition:

Instruction: Print or type the beneficiary's home address and telephone #, including area code.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 3

DATA FIELD: HSP (MEDICAID/NJ FamilyCare or CSOCI) Case No.

R

Definition:

Instruction: Print or type the first ten (10) digits of the beneficiary's Medicaid identification number.

Field Characteristics: It is a 10 position, numeric field.

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 4

DATA FIELD: Person No. R

Definition: The two (2) digit number that designates the beneficiary's Eligibility identification Person number.

Instruction: Print or type the last two (2) digits of the beneficiary's Medicaid Identification number.

Field Characteristics: It is a 2 position, numeric field.

Values:

Notes: PFC is the current program name for CSOCI.

EFFECTIVE: September, 2001 **FORM LOCATOR** 5

DATA FIELD: Date of Birth

R

Definition:

Instruction: Print or type the beneficiary's date of birth using the month, day, and year (MM/DD/YY) format. For example, September 10, 1981 is entered as 09/10/81.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 6

DATA FIELD: Sex

R

Definition:

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

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 7

DATA FIELD: Place of Service - Name and Address | R |

Definition:

Instruction: Print or type the name and address of the location where the service is provided.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 8

DATA FIELD: PROVIDER OF SERVICE INFORMATION R

Definition:

Instruction: Print or type the provider's name, address, telephone #, and the seven (7)-digit Medicaid Provider ID #. If the addresses in Form Locator (field) 7 and 8 are identical, print or type "same" in Form Locator 8.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 9

DATA FIELD: Brief Clinical History

R

Definition:

Instruction: Print or type a brief clinical history of the beneficiary including the date and location of the beneficiary's last treatment or hospitalization.

Field Characteristics:

Values:

Notes: Providers using the FD-07 (rev. 09/01), print or type this information in Form Locator (field) 9A on the FD-07A (rev. 09/01).

EFFECTIVE: September, 2001 **FORM LOCATOR** 10

DATA FIELD: Present Clinical Status R

Definition:

Instruction: Print or type the current clinical status of the beneficiary.

Field Characteristics:

Values:

Notes: Providers using the FD-07 (rev. 09/01), print or type this information in Form Locator (field) 10A on the FD-07A (rev. 09/01).

EFFECTIVE: January 1, 2014 **FORM LOCATOR** 11

DATA FIELD: Diagnosis and Code and Current Medications R

Definition:

Instruction: Print or type a valid and appropriate diagnosis code with a brief narrative description of the diagnosis. List name, dose and frequency of current medications.

Field Characteristics:

Values:

Notes: Providers using the FD-07 (rev. 09/01), print or type this information in Form Locator (field) #11A on the FD-07A (rev. 09/01).

EFFECTIVE: September, 2001 **FORM LOCATOR** 12 A-M

DATA FIELD: Treatment Request R

Definition:

Instruction: Print or type the # of visits that have been included in the treatment plan. Check the box that indicates the length of each session. Print or type the code # for each psychological test that is included in the treatment plan. If "other", print or type the specific service requested.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 13

DATA FIELD: Requested Date(s)

R

Definition:

Instruction: Print or type the requested "from" and "thru" dates of service using the month, day, and year (MM/DD/YY) format.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 14

DATA FIELD: AUTHORIZED DATE(S): NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 15

DATA FIELD: Reviewer ID Review Date NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16

DATA FIELD: PRIOR AUTHORIZED SERVICES DETAIL NR

Definition:

Instruction: Print or type the authorized service(s) information.

Field Characteristics:

Values:

Notes: All gray shaded areas are for the use of a DMAHS consultant.

EFFECTIVE: September, 2001 **FORM LOCATOR** 16A

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16B

DATA FIELD: REVENUE CODE OR PROCEDURE & MODIFIER CODE REQUESTED

R

Definition:

Instruction: Print or type the Revenue Code or the five (5)-digit HCPCS procedure code and two (2)-digit modifier, if applicable.

Field Characteristics:

Values:

Notes: A list of appropriate HCPCS codes are located in the Provider Manual. Definitions of the Level I procedure codes are located in the American Medical Association Physicians' Current Procedure Terminology.

EFFECTIVE: September, 2001 **FORM LOCATOR** 16C

DATA FIELD: REVENUE CODE OR PROCEDURE & MODIFIER CODE APPROVED

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16D

DATA FIELD: Units Requested

R

Definition:

Instruction: Print or type the # of days or other units of service (visits), as applicable.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16E

DATA FIELD: Units Approved NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16F

DATA FIELD: Unlabeled

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16G

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16H

DATA FIELD: Description of Service R

Definition:

Instruction: Print or type a brief description of the service(s) to be rendered.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16l

DATA FIELD: TOTAL FEE REQUESTED R

Definition:

Instruction: Print or type the provider's usual and customary charge for each service or procedure. This amount must reflect the total charge for all days or units of service for the detail line. For example, five (5) units of service at $5.00 per unit would be shown as 2500. Do not use $ signs or decimal points.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16J

DATA FIELD: TOTAL FEE APPROVED NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16K

DATA FIELD: Unlabeled NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 16L

DATA FIELD: Status NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

PA #12_____

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REQUEST FOR PRIOR AUTHORIZATION
SUPPLEMENTAL INFORMATION

Provider Information:

Name

Address

Provider Number

Beneficiary Information:

Name

Eligibility ID Number

Contact Person:

Name

Telephone Number

9a BRIEF CLINICAL HISTORY

10a PRESENT CLINICAL STATUS (to support request)

11a DIAGNOSIS AND CODE (must conform with ICD-9-CM) AND CURRENT MEDICATIONS

17 TREATMENT PLAN AND GOALS

18 ADDITIONAL CLINICAL INFORMATION (include all modifications of treatment/medication)

19. RESERVED FOR USE BY DMAHS CONSULTANT

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EFFECTIVE: September, 2001 **FORM LOCATOR** 9A

DATA FIELD: BRIEF CLINICAL HISTORY R

Definition:

Instruction: Print or type a brief clinical history of the beneficiary, including the date and location of last treatment or hospitalization.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 10A

DATA FIELD: PRESENT CLINICAL STATUS | R |

Definition:

Instruction: Print or type the current clinical status of the beneficiary.

Field Characteristics:

Values:

Notes:

EFFECTIVE: January 1, 2014 **FORM LOCATOR** 11A

DATA FIELD: DIAGNOSIS AND CODE AND CURRENT MEDICATIONS

R

Definition:

Instruction: Print or type a valid diagnosis code, and a brief narrative description of the diagnosis. List name, dosage, and frequency of current medications.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 17

DATA FIELD: TREATMENT PLAN AND GOALS R

Definition:

Instruction: Print or type a brief description of the treatment plan and the goals for the beneficiary that the requested services apply to.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 18

DATA FIELD: ADDITIONAL CLINICAL INFORMATION R

Definition:

Instruction: Print or type a description of any modifications in the treatment and/or medications.

Field Characteristics:

Values:

Notes:

EFFECTIVE: September, 2001 **FORM LOCATOR** 19

DATA FIELD: RESERVED FOR USE BY DMAHS CONSULTANT

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

5.2.1 Request for Prior Authorization Home APNEA Monitor Certification (FD-287)

This section provides form locator instructions for the completion of the following PA form:

Home Apnea Monitor Certification **FD-287 (Rev. 9/91)**

The FD-287 is a two (2)-ply form used when a provider is requesting approval for Home Apnea Monitor service that requires a PA.

SAMPLE

Indicates the **Field #** on the FD-287 claim form.

1. RECIPIENT'S LAST NAME, FIRST NAME MI

EFFECTIVE: September 2010 **FORM LOCATOR** 1

DATA FIELD: Recipient's Last Name First Name MI R

Title of field.

Field is **required** to be completed.

What the DATA FIELD means.

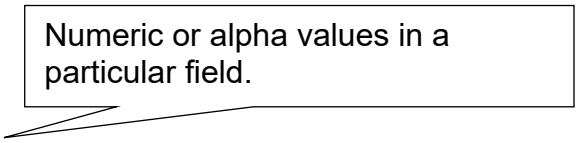
Definition: Beneficiary's full name

How to fill out the DATA FIELD.

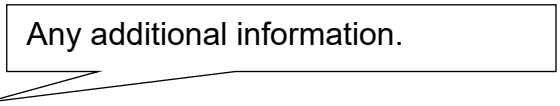
Instruction: Print or type the beneficiary's name EXACTLY as it is printed on the Medicaid Eligibility Identification Card. Last name first, first name, middle initial (M.I.).

The # of spaces in a particular field. Alpha, numeric or both.

Field Characteristics:



Values:



Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required or only if applicable.

R	= Field REQUIRED
NR	= Field NOT REQUIRED
OR	= Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

Prior Authorization Guidelines

- The PA number, preprinted on the upper right corner of the FD-287 (rev.9/91) must be appropriately transferred to and designated on the submitted claim form by the provider. It should be noted that the required PA number is indicated on the notification notice distributed by Gainwell Technologies to each provider in response to each submitted PA request.

- Print the information legibly, completely, and correctly.

- Print or type all dates using the month, day, and year (MM/DD/YY) format. For example, September 10, 2010 is entered 09/10/10.

- Provide all required information for every PA service detail line.

- Include a decimal point and "cents" positions for all dollar amounts. For example, enter 25.00, not 25. Do not use $ sign.

- Verify the accuracy of all information before submitting the appropriate form for a PA.

NOTE: PA requests for approval of Home Apnea Monitor services are submitted to the recipient's respective MACC office.

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

HOME APNEA MONITOR CERTIFICATION

PA#_____

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number ( ) -
3. HSP (MEDICAID) Case No.	4. Person No.	5. Date of Birth	6. Sex ☐ Male ☐ Female	City State ZIP Code
7. Parent/Guardian's Name			8. Parent/Guardian's Street Address (if different from above)	Telephone Number ( ) -
			City State ZIP Code	

9. PROVIDER OF SERVICE INFORMATION

Telephone Number ( ) -

Medicaid Provider Number (Enter only when not printed below)

Name and Address

10. COMPLETE FOR INITIAL CERTIFICATION (Completed from must be submitted within 21 days following initial verbal authorization)

Diagnosis: _____

Physician Ordering Monitor: _____

Physician's Telephone No.: _____

11. COMMENTS:

12. Must Be Completed By The Physician For Initial Request

I certify that:

A. The above named child needs a home apnea monitor for the following diagnosis:

( ) Apnea of Prematurity ( ) Infantile Apnea ( ) ALTE Age at Onset _____ ( ) Relative of SIDS Relationship _____ ( ) Other Explain _____

Comments: _____

Projected length of monitoring is: _____

If child was hospitalized for the above condition, please give name of hospital _____ and date of discharge _____

B. ( ) I will provide follow-up care for the above condition. The date of the next visit is _____

OR

( ) I am referring the child for apnea follow-up to: Name of physician: _____

Telephone No. ( ) _____ Date of next visit: _____

Physician's Signature Date

13. Must Be Completed By Physician For Reauthorization

I certify that:

A. I examined the child on (give date) _____

B. The child is ( ) asymptomatic ( ) symptomatic for apnea.

C. ( ) The child continues to need home apnea monitor because _____

D. ( ) The monitor may be discontinued on (give date) _____

Physician's Signature Date

14. REQUESTED DATE(S) (NOTE: MAY NOT EXCEED 3 MONTHS)	15. AUTHORIZED DATE(S) (NOTE: MAY NOT EXCEED 3 MONTHS)	16. Reviewer ID	Review Date
From: _____ Thru: _____	From: _____ Thru: _____		

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 6 SERVICES) GRAY SHADED AREA FOR DIVISION USE ONLY

A.	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F.	G.	H. Description of Service	I. TOTAL FEE REQUESTED	J. FEE APPROVED	K.	L. Status

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

HOME APNEA MONITOR CERTIFICATION

PA#_____

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number ( ) -
3. HSP (MEDICAID) Case No.	4. Person No.	5. Date of Birth	6. Sex ☐ Male ☐ Female	City State ZIP Code
7. Parent/Guardian's Name			8. Parent/Guardian's Street Address (if different from above)	Telephone Number ( ) -
			City State ZIP Code	

9. PROVIDER OF SERVICE INFORMATION

Telephone Number ( ) -

Medicaid Provider Number (Enter only when not printed below)

Name and Address

10. COMPLETE FOR INITIAL CERTIFICATION (Completed from must be submitted within 21 days following initial verbal authorization)

Diagnosis: _____

Physician Ordering Monitor: _____

Physician's Telephone No.: _____

11. COMMENTS:

12. Must Be Completed By The Physician For Initial Request

I certify that:

A. The above named child needs a home apnea monitor for the following diagnosis:

( ) Apnea of Prematurity ( ) Infantile Apnea ( ) ALTE Age at Onset _____ ( ) Relative of SIDS Relationship _____ ( ) Other Explain _____

Comments: _____

_____

Projected length of monitoring is: _____

If child was hospitalized for the above condition, please give name of hospital _____ and date of discharge _____

B. ( ) I will provide follow-up care for the above condition. The date of the next visit is _____

OR

( ) I am referring the child for apnea follow-up to: Name of physician: _____

Telephone No. ( ) _____ Date of next visit: _____

_____
Physician's Signature Date

13. Must Be Completed By Physician For Reauthorization

I certify that:

A. I examined the child on (give date) _____

B. The child is ( ) asymptomatic ( ) symptomatic for apnea.

C. ( ) The child continues to need home apnea monitor because _____

D. ( ) The monitor may be discontinued on (give date) _____

_____
Physician's Signature Date

14. REQUESTED DATE(S) (NOTE: MAY NOT EXCEED 3 MONTHS)	15. AUTHORIZED DATE(S) (NOTE: MAY NOT EXCEED 3 MONTHS)	16. Reviewer ID	Review Date
From: _____ Thru: _____	From: _____ Thru: _____		

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 6 SERVICES) GRAY SHADED AREA FOR DIVISION USE ONLY

A.	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F.	G.	H. Description of Service	I. TOTAL FEE REQUESTED	J. FEE APPROVED	K.	L. Status

EFFECTIVE: March 2010 **FORM LOCATOR** 1

DATA FIELD: Recipient's Last Name First Name MI | R |

Definition:

Instruction: Print or type the beneficiary's name EXACTLY as it is printed on the Health Benefits Identification Card. Last name, first name, middle initial (M.I.).

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 2

DATA FIELD: Recipient's Street Address Telephone Number

R

Definition:

Instruction: Print or type the beneficiary's complete home address and telephone number, including area code.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 3

DATA FIELD: HSP (MEDICAID) Case No.

R

Definition:

Instruction: Print or type the first ten (10) digits of the beneficiary's Medicaid Case Identification number.

Field Characteristics:

Values:

Notes: Providers can obtain the Beneficiary's Medicaid Identification Number by verifying eligibility through eMEVS, MEVS, or REVS.

EFFECTIVE: March 2010 **FORM LOCATOR** 4

DATA FIELD: Person No.

R

Definition:

Instruction: Print or type the last two (2) digits of the beneficiary's Medicaid Identification number.

Field Characteristics:

Values:

Notes: Providers can obtain the Beneficiary’s Medicaid Identification Number by verifying eligibility through eMEVS, MEVS, or REVS.

EFFECTIVE: March 2010 **FORM LOCATOR** 5

DATA FIELD: Date of Birth

R

Definition:

Instruction: Print or type the beneficiary's date of birth using the month, day, and year (MM/DD/YY) format. For example, September 10, 2010 is entered as 09/10/10.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 6

DATA FIELD: Sex

R

Definition:

Instruction: Check the box to indicate the beneficiary's sex.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 7

DATA FIELD: Parent/Guardian's Name R

Definition:

Instruction: Print or type the beneficiary's parent or guardian's name.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 8

DATA FIELD: Parent/Guardian's Address OR

Definition:

Instruction: Print or type the parent/guardian's complete home address and telephone number, if different from Form Locator 2.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 9

DATA FIELD: PROVIDER OF SERVICE INFORMATION R

Definition:

Instruction: Print or type the provider's name, address, telephone number, and the seven (7)-digit Medicaid Provider ID #.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 10

DATA FIELD: COMPLETE FOR INITIAL CERTIFICATION | R |

Definition:

Instruction: Complete all items. Print or type the diagnosis description.

Field Characteristics:

Values:

Notes: The form must be completed within 21 days following his initial verbal emergency authorization.

EFFECTIVE: March 2010 **FORM LOCATOR** 11

DATA FIELD: COMMENTS OR

Definition:

Instruction: Print or type comments as appropriate.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12

DATA FIELD: Must Be Completed by The Physician For Initial Request

R

Definition:

Instruction: Complete all items. Physician must sign and date the form.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 13

DATA FIELD: Must Be Completed By Physician For Reauthorization

OR

Definition:

Instruction: Complete all items for reauthorization only. Must be completed by physician responsible for Apnea follow-up whenever re-authorization is requested.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 14

DATA FIELD: REQUESTED DATE(S)

R

Definition:

Instruction: Print or type the requested from and thru dates of service using the month, day, and year (MM/DD/YY) format.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15

DATA FIELD: AUTHORIZED DATE(S): NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 16

DATA FIELD: Reviewer ID Review Date

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17A

DATA FIELD: Unlabeled

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17B

DATA FIELD: PROCEDURE & MODIFIER CODE REQUESTED

R

Definition:

Instruction: Print or type the five (5)-digit HCPCS procedure code and two (2)-digit modifier, if applicable.

Field Characteristics:

Values:

Notes: A list of commonly used HCPCS codes is located in the Provider Manual.

EFFECTIVE: March 2010 **FORM LOCATOR** 17C

DATA FIELD: PROCEDURE & MODIFIER CODE APPROVED

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17D

DATA FIELD: Units Requested

R

Definition:

Instruction: Print or type the number of days or other units of service (visits).

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17E

DATA FIELD: Units Approved

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17F

DATA FIELD: Unlabeled

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17G

DATA FIELD: Unlabeled

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17H

DATA FIELD: Description of Service

R

Definition:

Instruction: Print or type a brief description of the service(s) to be rendered.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17I

DATA FIELD: TOTAL FEE REQUESTED

R

Definition:

Instruction: Print or type the provider's usual and customary charge for each service or procedure. This amount must reflect the total charge for all days or units of service for the detail line. For example, five (5) units of service at $5.00 per unit would be shown as 25.00. Do not use a $ sign.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17J

DATA FIELD: FEE APPROVED

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17K

DATA FIELD: Unlabeled

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17L

DATA FIELD: Status

NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

5.2.2 Physician Certification FD-179 (Rev. 7/95)

This form is used by the provider to certify the medical necessity of induced abortion procedures.

A completed Physician Certification form, FD-179, must be attached to any claim (physician, hospital, anesthesiologist, clinic, etc.) involving an abortion procedure when the claim is submitted for payment. Claims for abortion services are hard copy restricted; electronic billing is not permitted.

Providers may obtain additional copies of the FD-179 form from Gainwell Technologies; however, photocopies of the FD-179 are acceptable.

A sample of the Physician Certification and the instructions for the form's proper completion are included for reference.

SAMPLE

Indicates the **Field #** on the FD-179 claim form.

A. Beneficiary's Name

EFFECTIVE: July 1995 **FORM LOCATOR** A

DATA FIELD: Beneficiary's Name

R

Field is **required** to be completed.

Title of field.

What the DATA FIELD means.

Definition: First name, middle initial and last name of the patient.

How to fill out the DATA FIELD.

Instruction: Print or type the beneficiary's name as it appears on the Medicaid Eligibility Identification Card. First name must be first.

The # of spaces in a particular field. Alpha, numeric or both.

Field Characteristics:

Numeric or alpha values in a particular field.

Values:

Any additional information.

Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required or only if applicable.

R	= Field REQUIRED
NR	= Field NOT REQUIRED
OR	= Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHYSICIAN CERTIFICATION

A Beneficiary's Name _____

B Beneficiary's Address _____

C Beneficiary's MEI (Medicaid Eligibility Identification) Case Number _____

D I certify that it was medically necessary to perform an abortion on the Medicaid beneficiary indicated above, for the following reasons:

- ☐ To save the life of the mother; or (0)
- ☐ The pregnancy was the result of an act of rape; or (1)
- ☐ The pregnancy was the result of an act of incest (2)
- ☐ In my professional judgment, the abortion was medically necessary and consistent with the Federal court ruling that a physician may take the following factors into consideration in determining whether an abortion is medically necessary (3)

  Physical, emotional and psychological factors;

  Family reasons;

  Age.

E _____ F _____ G _____

Signature of physician who performed the abortion *Medicaid Provider Service Number* *Date*

FD-179 (Rev. 7/95)

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EFFECTIVE DATE: July 1995 **FORM LOCATOR** A

DATA FIELD: Beneficiary's Name

R

Definition:

Instruction: Print or type the beneficiary's name; first name must be first.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE DATE: July 1995 **FORM LOCATOR** B

DATA FIELD: Beneficiary's Address R

Definition: The location of the patient's residence.

Instruction: Print or type the patient's complete home address.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE DATE: July 1995 **FORM LOCATOR** C

DATA FIELD: Beneficiary's MEI (Medicaid Eligibility Identification) Case Number

R

Definition: The twelve (12) digit number that designates the beneficiary's Medicaid Eligibility Identification number.

Instruction: Print or type the twelve (12) digits of the beneficiary's MEI Case Number and Person Number **EXACTLY** as it is printed on the Medicaid Eligibility Identification Card.

Field Characteristics: It is a 12 position numeric field.

Values:

Notes:

EFFECTIVE DATE: July 1995 **FORM LOCATOR** D

DATA FIELD: Certifying Medically Necessary | R |

Definition: The reason for the abortion based on medical necessity.

Instruction: Check the box that certifies the reason for the abortion.

- To save the life of the mother; or (0)
- The pregnancy was the result of an act of rape; or (1)
- The pregnancy was the result of an act of incest; or (2)
- In my professional judgment, the abortion was medically necessary and consistent with the Federal court ruling that a physician may take the following factors into consideration in determining whether an abortion is medically necessary (3).

    - Physical, emotional and psychological factors;
    - Family reasons;
    - Age.

Field Characteristics: It is a 1 position alpha field.

Values:

Notes:

EFFECTIVE DATE: July 1995 **FORM LOCATOR** E

DATA FIELD: Signature of Physician | R

Definition: The signature of the physician who performed the abortion.

Instruction: The physician who performs the abortion must sign the form.

Field Characteristics:

Values:

Notes: No stamped signatures will be accepted.

EFFECTIVE DATE: July 1995 **FORM LOCATOR** F

DATA FIELD: Medicaid Provider Service Number | R |

Definition: The New Jersey Medicaid Provider ID # of the physician who performed the abortion.

Instruction: The physician who performs the abortion must print or type his/her seven (7) digit NJ Medicaid Provider ID #.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: July 1995 **FORM LOCATOR** G

DATA FIELD: Date

R

Definition: The date the physician who completed the FD-179 form.

Instruction: The physician who performed the abortion must print or type the date that he/she signed the form.

Field Characteristics:

Values:

Notes:

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5.2.3 Hysterectomy Receipt Of Information Form - FD-189 (Rev. 3/91)

Federally described documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form, FD-189. Any claim (hospital, operating physician, anesthesiologist, clinic, etc.) involving hysterectomy procedures must have a properly completed FD-189 attached when submitted for payment. Hysterectomy claims are hard copy restricted; electronic billing is not permitted.

Providers may obtain additional copies of the FD-189 form from the Fiscal Agent; however, photocopies of the FD-189 are acceptable.

A sample of the Hysterectomy Receipt of Information Form and instruction's for the form's proper completion are included for reference.

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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF HEALTH ASSISTANCE AND HEALTH SERVICES

HYSTERECTOMY RECEIPT OF INFORMATION SERVICES

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You can not have a baby after your uterus is removed and you will not have menstrual periods anymore.

I received the above information from **A**
(name of clinic or physician)
before my operation was performed. I talked to **B**
(name of responsible person(s)
about a hysterectomy.

C discussed it with me and gave me a chance to ask questions and answered all
(She/He/They)
questions before the operation.

I have read this notice. I agree that it is a true description of what was explained to me by **D** (name of staff member) of **E** (clinic/hospital/physician) and that all my questions were answered to my satisfaction.

I, **F**, hereby consent (or did consent) of my own free will to have a hysterectomy done by **G** and/or associate(s) or assistant(s) of his or her choice.

I consent (or did consent) to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department **but only for purposes of** determining **if Federal laws were observed**.

H
Beneficiary's Signature

I
Date: Month/Day/Year

FD-189 (rev. 05/23)

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EFFECTIVE DATE: March 2010 **FORM LOCATOR** A

DATA FIELD: Clinic or Physician Name | R

Definition: Name of Clinic or Physician

Instruction: Print or type the name of the clinic or physician that gave the information to the beneficiary.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** B

DATA FIELD: Name of Responsible Person(s) R

Definition: Name of individual that discussed the procedure with the beneficiary.

Instruction: Print or type the name of the individual who discussed the procedure with the beneficiary.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** C

DATA FIELD: She/He/They

R

Definition: She/He/They

Instruction: Print or type the appropriate selection.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** D

DATA FIELD: Name of Staff Member | R |

Definition: The name of the staff member that explained the procedure to the beneficiary.

Instruction: Print or type the name of the individual who discussed the procedure with the beneficiary.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** E

DATA FIELD: Clinic/Hospital/Physician R

Definition: Name of the clinic, hospital, or physician's office in which the individual who explained the procedure is affiliated.

Instruction: Print or type the name of the clinic, hospital, or physicians office in which the individual who explained the procedure is affiliated.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** F

DATA FIELD: Beneficiary's Name | R |

Definition: The first and last name of the beneficiary having the surgery.

Instruction: Print or type the first and last name of the beneficiary EXACTLY as it is printed on the Health Benefits Identification Card.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** G

DATA FIELD: Name of Surgeon

R

Definition:

Instruction: Print or type the name of the physician performing the surgery.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** H

DATA FIELD: Beneficiary's Signature

R

Definition: The beneficiary's original signature.

Instruction: The beneficiary signs the form.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR** I

DATA FIELD: Date: Month/Day/Year

R

Definition: The date the form was signed by the beneficiary.

Instruction: The beneficiary prints or types the date that he/she signed the form.

Field Characteristics:

Values:

Notes:

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5.2.4 Consent Form-7473-M ED 3-81

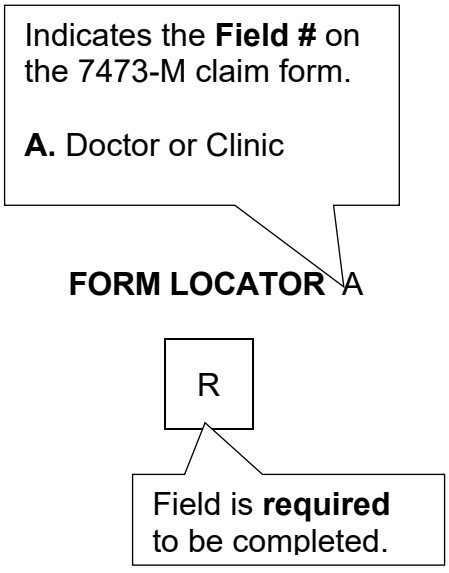
Federally prescribed documentation regulations for sterilization procedures are extremely rigid. Specific Medicaid requirements must be met and documented on the Consent Form-7473-M prior to the sterilization of an individual.

The Consent Form-7473-M is a replica of the form contained in the Federal Regulations and must be utilized by providers when submitting claims for sterilization procedures. Any claim (hospital, operating physician, anesthesiologist, clinic, etc.) involved in a sterilization procedure must have a properly completed Consent Form-7473-M attached to the claim when it is submitted for payment. Sterilization claims are hard copy restricted; electronic billing is not permitted.

Providers may obtain additional copies of the Consent Form-7473-M from Gainwell Technologies; however, photocopies of the Consent Form-7473-M are acceptable.

A sample of the Consent Form-7473-M and instructions for the form's proper completion are provided for reference.

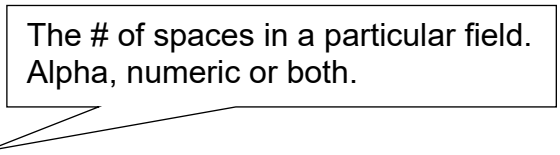
SAMPLE



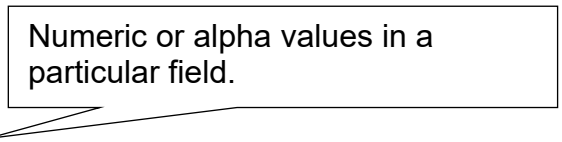
Definition: The doctor or clinic where the sterilization consent form and information were received.

How to fill out the DATA FIELD.

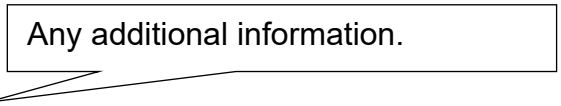
Instruction: Print or type the name of the physician or clinic.



Field Characteristics:



Values:



Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required or only if applicable.

R	= Field REQUIRED
NR	= Field NOT REQUIRED
OR	= Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

CONSENT FORM

Notice: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

o CONSENT TO STERILIZATION o

I have asked for and received information about sterilization from _____**A**_____. When I first asked for the
(Doctor or Clinic)
information. I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT. BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____**B**_____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on
_____**C**_____, (Month Day Year)

I, _____**D**_____, hereby consent of my own free will to be sterilized by _____**E**_____ by a method (Doctor)
called _____**F**_____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal Laws were observed.

I have received a copy of this form.

_____**G**_____ Date:_____**H**_____
Signature Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check) **I**

___ American Indian or Alaska Native
___ Asian or Pacific Islander
____ Black (not Hispanic origin)
____ Hispanic
____ White (not of Hispanic origin)

o INTERPRETER'S STATEMENT o

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____**J**_____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____**J1**_____ _____**J2**_____
Interpreter Date

o STATEMENT OF PERSON OBTAINING CONSENT o

Before _____**K**_____ signed the consent
(Name of Individual)
form, I explained to him/her the nature of the sterilization operation _____**L**_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____**M**_____
Signature of person obtaining consent Date

_____**N**_____
Facility

_____
Address

o PHYSICIAN'S STATEMENT o

Shortly before I performed a sterilization operation upon
_____**O**_____
(Name of individual to be sterilized)
on _____**P**_____, I explained to
(Date of sterilization operation)
him/her the nature of the sterilization operation _____**Q**_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

R (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

____Premature delivery;
____Individual's expected date of delivery;
____Emergency abdominal surgery:
(describe circumstances):

_____**S**_____
Physician
Date_____**T**_____

7473-M ED 3-81

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SECTION I CONSENT TO STERILIZATION

EFFECTIVE DATE: **FORM LOCATOR** A

DATA FIELD: Doctor or Clinic

R

Definition: The doctor or clinic where the sterilization consent form and information were received.

Instruction: Print or type the name of the physician or clinic.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** B

DATA FIELD: Unlabeled

R

Definition: The name of the sterilization procedure.

Instruction: Print or type the name of the sterilization procedure.

Field Characteristics:

Values:

Notes: 1) Keep the name of the procedure consistent throughout this document.

2) Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** C

DATA FIELD: Unlabeled

R

Definition: The date of birth of the beneficiary.

Instruction: Print or type the beneficiary's date of birth using the month, day, and year (MMDDYY) format. For example, September 10, 1971 is entered 091071.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** D

DATA FIELD: Unlabeled

R

Definition: The first name, middle initial, and last name of the beneficiary.

Instruction: Print or type the beneficiary's name EXACTLY as it is printed on the Health Benefits Identification Card. First name must be entered first.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** E

DATA FIELD: Doctor

R

Definition: Physician's name.

Instruction: Print or type the name of the physician who performed the procedure.

Field Characteristics:

Values:

Notes: 1. This is the same name as reported in Form Locator B.

2. Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** F

DATA FIELD: Unlabeled

R

Definition:

Instruction: Print or type the method of sterilization.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** G&H

DATA FIELD: Signature Date

R

Definition: Signature of beneficiary and date of signature.

Instruction: The beneficiary must sign and date the form at least 30 days, but not more than 180 days, prior to surgery.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

SECTION II RACE AND ETHNICITY DESIGNATION

EFFECTIVE DATE: **FORM LOCATOR** I

DATA FIELD: Race and Ethnicity Designation | OR

Definition:

Instruction: Check the line, as appropriate.

Field Characteristics:

Values:

Notes:

1) This optional information is requested by the Federal Government, but is not required.

2) Items A thru N must be completed at the time of the consent.

SECTION III INTERPRETER'S STATEMENT: TO BE USED ONLY WHEN THE BENEFICIARY DOES NOT SPEAK ENGLISH

EFFECTIVE DATE: **FORM LOCATOR** J

DATA FIELD: INTERPRETER'S STATEMENT | OR

Definition: Language understood by beneficiary. Used *only* when the beneficiary does not speak English.

Instruction: Print or type the "type" of language used.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** J1

DATA FIELD: Interpreter

OR

Definition: Signature of interpreter.

Instruction: The interpreter must sign the form at least 30 days, but not more than 180 days, prior to the sterilization procedure.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** J2

DATA FIELD: Date

OR

Definition: Date of interpreter's signature.

Instruction: The interpreter must date the form at least 30 days, but not more than 180 days, prior to the sterilization procedure.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

SECTION IV STATEMENT OR PERSON OBTAINING CONSENT

EFFECTIVE DATE: **FORM LOCATOR** K

DATA FIELD: Name of Individual

R

Definition: The name of beneficiary.

Instruction: Print or type the name of the beneficiary EXACTLY as it is printed in Section I, Form Locator (field) D.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** L

DATA FIELD: Unlabeled

R

Definition: The name of the sterilization procedure.

Instruction: Print or type the name of the sterilization procedure.

Field Characteristics:

Values:

Notes: 1) Keep the name of the procedure consistent throughout this document.

2) This is the same name reported in Section 1, Form Locators B and F,

3) Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** M

DATA FIELD: Signature of person obtaining consent Date | R |

Definition: The name of person who obtains the beneficiary's consent.

Instruction: The signature and date of the person who explains the procedure to the beneficiary and obtains the beneficiary's consent. This must be completed at least 30 days, but not more than 180 days, prior to the sterilization procedure.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** N

DATA FIELD: Facility Address

R

Definition: The facility's full name and address.

Instruction: Print or type the full name and address (including the zip code) of the facility or physician's office with which the person obtaining the consent is affiliated.

Field Characteristics:

Values:

Notes: Items A thru N must be completed at the time of the consent.

EFFECTIVE DATE: **FORM LOCATOR** O

DATA FIELD: Unlabeled

R

Definition: The name of beneficiary.

Instruction: Print or type the beneficiary's name EXACTLY as it is printed in Section I, Item D.

Field Characteristics:

Values:

Notes: Items O thru T must be completed after the procedure has been performed.

EFFECTIVE DATE: **FORM LOCATOR** P

DATA FIELD: Date of sterilization operation

R

Definition: The date of the sterilization procedure.

Instruction: Print or type the date of the sterilization in month, day, and year (MM/DD/YY) format. For example, September 10, 2001 is entered 091001.

Field Characteristics:

Values:

Notes: Items O thru T must be completed after the procedure has been performed.

EFFECTIVE DATE: **FORM LOCATOR** Q

DATA FIELD: Unlabeled

R

Definition: The name of the sterilization procedure.

Instruction: Print or type the name of the sterilization procedure.

Field Characteristics:

Values:

Notes:

1. Keep the name of the procedure consistent throughout this document.
2. This is the same name reported in Section 1, form Locators B and F.
3. Items O thru T must be completed after the procedure has been performed.

EFFECTIVE DATE: **FORM LOCATOR** R

DATA FIELD: Paragraph (1) and (2)

R

Definition:

Instruction: The physician must indicate the paragraph that applies to the beneficiary's situation.

Paragraph (1) states that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

Paragraph (2) states that the sterilization was performed less than 30 days, but more than 72 hours, after the date of the individual's signature on the consent form. The circumstances are premature delivery (state the expected date of delivery) or emergency abdominal surgery (describe the emergency).

Field Characteristics:

Values:

Notes:

1. If the 2nd paragraph is circled, the physician must place an "X" on the line that describes the circumstance.

2. Items O thru T must be completed after the procedure has been performed.

EFFECTIVE DATE: **FORM LOCATOR** S

DATA FIELD: Physician

R

Definition: The signature of the physician.

Instruction: The physician must sign the form *after* the surgery has been performed.

Field Characteristics:

Values:

Notes: Items O thru T must be completed after the procedure has been performed.

EFFECTIVE DATE: **FORM LOCATOR** T

DATA FIELD: Date

R

Definition: The date the physician signed.

Instruction: The physician must date the form the same day he/she signed (after the surgery has been performed).

Field Characteristics:

Values:

Notes: Items O thru T must be completed after the procedure has been performed.

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5.2.5 Medicaid Second Opinion Referral Form FD-263 (1/94)

The Second Opinion Referral form FD-263 is a five ply form. A copy must be attached to all claims associated with surgical procedures that require a second opinion. The Gainwell Technologies Second Opinion Specialist will enter the names of up to three Second Opinion Physicians and will mail this form to beneficiary upon request. There are four (4) procedures that require a second opinion, as follows.

1. Hysterectomy
2. Hernia Repair - For patients 19 years or older
3. Laminectomy
4. Spinal Fusion

Hysterectomy Only. Claims for a hysterectomy must have the Second Opinion Referral form FD-263 and a hysterectomy receipt of information form attached. As of September 30, 1991, the following procedure will be in effect:

- The Gainwell Technologies Second Opinion Representative will complete Part I of the Medicaid Second Opinion Referral form FD-263, retain one copy and mail the remaining four copies to the beneficiary.

- The beneficiary delivers the four copies to one of the Second Opinion physicians listed on the form. This Second Opinion physician completes Parts II and III, retains one copy (to be attached to the claim for the second opinion consultation) and returns three copies to the beneficiary.

- The beneficiary delivers these three copies to the referring physician.

- If a determination for surgery is made, the referring physician retains one copy (to be attached to the related claim form) and forwards the remaining two copies to the hospital where the surgery is to be performed. The Second Opinion Referral form FD-263 (1/94) is valid for one year from the date the Second Opinion Representative signed the form in Part I.

    o Submit both the 1500 claim and the copy of the Medicaid Second Opinion Referral form FD-263 to:

Gainwell Technologies
P. O. Box 4801
Trenton, NJ 08650-4801

NOTE: The Second Opinion Referral form FD-263 does not assure the eligibility of the beneficiary.

SAMPLE

Indicates the **Field #** on the FD-263 claim form.

EFFECTIVE: **FORM LOCATOR** A

DATA FIELD: PATIENT'S NAME

R

Title of field.

Field is **required** to be completed.

What the DATA FIELD means.

Definition: The doctor or clinic where the sterilization consent form and information were received.

How to fill out the DATA FIELD.

Instruction: Print or type the name of the physician or clinic.

The # of spaces in a particular field. Alpha, numeric or both.

Field Characteristics:

Numeric or alpha values in a particular field.

Values:

Any additional information.

Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required or only if applicable.

R = Field REQUIRED

NR = Field NOT REQUIRED

OR = Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

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

MEDICAID SECOND OPINION REFERRAL FORM

PART I REFERRAL CENTER INTAKE INFO

(First)	PATIENT'S STREET ADDRESS	TELEPHONE NO.
HSP (MEDICAID) CASE NO. _ _ _ _ _ _ _ _ _ PERSON NO. _ _	SEX ☐ Male ☐ Female	BIRTHDATE _ _ / _ _ / _ _
CITY	STATE	ZIP CODE
NAME OF REFERRING PHYSICIAN	TELEPHONE	RECOMMENDED PROCEDURE ☐ Hysterectomy ☐ Laminectomy ☐ Hernia Repair ☐ Spinal Fusion ☐ Tonsillectomy/adenoidectomy
OFFICE ADDRESS (Street, City, State, Zip Code)		
☐ SECOND OPINION ☐ THIRD OPINION	DATE OF CONTACT	OTHER INSURANCE ☐ NO ☐ YES ☐ IF YES, GIVE NAME OF COMPANY AND ID#

SECOND OPINION REFERRALS

NAME	SPECIALTY	ADDRESS	TELEPHONE NO.
1.			
2.			
3.			

Signature of Referral Center Designee _____ Date _____

ADMINISTRATIVE WAIVER ☐ YES ☐ NO

PART II CERTIFICATION

PHYSICIAN RENDERING SECOND OPINION: (PRINT) DATE OF APPOINTMENT

PATIENT RELEASE: I give my permission to release medical data collected as a result of this second opinion to the New Jersey Medicaid Referral Center and to the physicians involved in my care.

Signature of Patient or Authorized Representative _____ Date _____

PART III SECOND OPINION CONSULTATION REPORT

PATIENT DIAGNOSIS

SUMMARY OF FINDINGS/RECOMMENDATIONS

LIST LAB, X-RAY OR OTHER DIAGNOSTIC TESTS (WHEN APPLICABLE)--USE SEPARATE SHEET IF NECESSARY

DESCRIPTION OF TEST	RESULTS	DATE PERFORMED

SIGNATURE OF SECOND OPINION PHYSICIAN DATE RECOMMENDATION FOR SURGERY ☐ Concur ☐ Not Concur

This authorization is valid for one year from the date indicated above by the signature of the second opinion physician or in the event of an administrative waiver the date of signature of the referral center designee in Part I. This authorization is not a guarantee of the recipient's Medicaid eligibility. You are required to verify eligibility by viewing the Medicaid eligibility validation form.

FD-263 (1/94) 84149ed 1/94

SECOND OPINION PHYSICIAN

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EFFECTIVE: March 2010 **FORM LOCATOR**

DATA FIELD: PART I REFERRAL CENTER INTAKE INFO R

Definition:

Instruction: Do not complete.

Field Characteristics:

Values:

Notes: This is completed by the Gainwell Technologies Second Opinion Specialist.

Note to the Second Opinion Physician: Verify that your name is listed in Part I. If it is not, refer the beneficiary to one (1) of the identified physicians.

EFFECTIVE: March 2010 **FORM LOCATOR**

DATA FIELD: **PART II CERTIFICATION**
Physician Rendering Second Opinion (Print)

R

Definition: Physician rendering second opinion.

Instruction: Print or type the name of the physician rendering the second opinion.

Field Characteristics:

Values:

Notes: This is completed by the physician.

EFFECTIVE: March 2010 **FORM LOCATOR**

DATA FIELD: Date of the Appointment | R

Definition: The date of second opinion examination.

Instruction: Print or type the date of the second opinion examination.

Field Characteristics:

Values:

Notes: This is completed by the physician.

EFFECTIVE DATE: January 1, 2014 **FORM LOCATOR**

DATA FIELD: **PART III SECOND OPINION CONSULTATION REPORT**

PATIENT DIAGNOSIS

R

Definition: The patient's diagnosis.

Instruction: Print or type the diagnosis code and a brief narrative description of the diagnosis.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR**

DATA FIELD: SUMMARY OF FINDINGS/ RECOMMENDATIONS

R

Definition: The findings and recommendations.

Instruction: Print or type a summary of the findings and recommendations.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR**

DATA FIELD: DESCRIPTION OF TEST RESULTS
DATE PERFORMED

R

Definition:

Instruction: Print or type a description of the test(s), the results, and the date the test(s) were performed.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR**

DATA FIELD: SIGNATURE OF SECOND OPINION PHYSICIAN

R

Definition: The second opinion physician signature.

Instruction: The second opinion physician must sign the form.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR**

DATA FIELD: DATE | R

Definition: The date of the second opinion physician's signature.

Instruction: Print or type the date that the form was signed by the second opinion physician.

Field Characteristics:

Values:

Notes:

EFFECTIVE DATE: March 2010 **FORM LOCATOR**

DATA FIELD: RECOMMENDATION FOR SURGERY | R |

Definition: The concurrence with surgery

Instruction: Check the box, as appropriate.

Field Characteristics:

Values:

Notes:

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5.3 PROVIDER NOTIFICATION LETTER

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State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
P.O. BOX 726
TRENTON, NEW JERSEY 08625-0726

QUAKERBRIDGE PLAZA
PO BOX 712
TRENTON, NEW JERSEY 08625-0712

DATE: 03/08/04

PROVIDER INFORMATION

1234567
JULIAN SOSNER
100 BROADWAY
ANYTOWN, NJ 12345

BENEFICIARY INFORMATION

1111111111-01
JOSEPH ORANGE
50 CAROLINA RD
ATLANTIC CITY, NJ 08401

Dear Provider:

Your prior authorization request for health care service(s) or item(s) has been reviewed. The status of your request(s) for authorization is listed below.

The determination of this request for authorization to provide Medicaid services or item(s) is pursuant to N.J.A.C. 10-49-6.1.

Final reimbursement for all prior authorization services is governed by the limitations set forth by the New Jersey Medicaid Program.

If you wish to exercise your right to appeal the decision made regarding your request for authorization, you may submit a request for a fair hearing to:

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
FAIR HEARING UNIT
PO BOX 712
TRENTON, NEW JERSEY 08625-0712

Requests for a fair hearing must be offered in accordance with N.J.A.C. 10:49-10.2. submitted in writing twenty (20) days from the date of this letter.

FD-360 (Rev 9/91)

Prior Authorization Number: 1199999998 **Reviewer ID: 329**
Authorized From: 09/01/01 Thru: 12/31/01 **Review Date: 02/28/01**

STATUS	PROC. CODE	DESCRIPTION
APPROVED	90804 (HCPCS CODE)	PSYCHOTHERAP 20-30 MIN
DENIED	90806 (HCPCS CODE)	PSYCHOTHERAPY 45-50 MIN

Denied Reason: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MODIFIED	90801 (HCPCS CODE)	DIAGNOSTIC INTERVIEW

Modified Reason: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SUSPENDED	90805 (HCPCS CODE)	INDIVIDUAL MEDICAL MANAGEMENT

6.0 PHYSICIAN SERVICES

This section provides the information necessary to complete the Physician Services claim forms.

NOTE: Forms that are not legible will be returned to the provider.

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6.1 Health Insurance Claim Form (1500)

This section provides form locator instructions for completion of the 1500 claim form and the Report and Claim for EPSDT/HealthStart Screening (MC-19) and Related Procedures for Medicaid approved independent clinic services. Examples of correctly completed forms for Medicaid-covered services are provided for reference.

SAMPLE

Indicates the **Field #** on the 1500 claim form.

1a. INSURER'S ID NUMBER

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 1a

DATA FIELD: INSURER'S ID NUMBER

R

Title of field.

Field is **required** to be completed.

What the DATA FIELD means.

Definition: The beneficiary's 12-digit NJ Medicaid ID #.

How to fill out the DATA FIELD.

Instruction: Print or type the beneficiary's 12-digit NJ Medicaid ID #.

The # of spaces in a particular field. Alpha, numeric or both.

Field Characteristics:

Only used for Form Locator 24b and 24c.

Values:

Any additional information.

Notes:

On the instruction sheets, the following values identify whether or not the field is required, not required, or only if applicable.

R	= Field REQUIRED
NR	= Field NOT REQUIRED
OR	= Field ONLY IF APPLICABLE, otherwise LEAVE BLANK

All forms not legible will be returned to the provider with the Return to Provider Form (RPF). Upon correction, claims should be mailed to:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

Claim Completion Tips

- Use no more than six (6) claim service detail lines on each 1500.
- Total Charge (Item 28) and Amount Paid (Item 29) must be totaled on each claim form as an independent submission. These items may not continue from one claim form to another.
- Information must be printed or typed legibly, completely and correctly using a typewriter, printer, or ballpoint pen (black ink only).
- Date format is Month, Day and Year (MM/DD/YY). Example September 10, 2010 is entered as 091010.
- Do not use words such as "ditto" or "same as above".
- Verify all information on the 1500 before submission.
- Effective January 2012 any claims that do not have an attachment will be returned to the provider - reference Newsletter Vol. 21 No. 25.

Check Points:

- Is my Provider ID # in the correct field?
- Is my NPI number in the correct field?
- Are all the required fields completed?
- Are my forms legible?
- Did I sign and date my claim?
- Is my envelope addressed to the correct P.O. Box?
- Do not highlight claims or attachments.
- Do not use stamps, initials, or computer generated signatures. They are not acceptable on the claim.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO ___	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, complete items 9, 9a and 9d.
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 below. SIGNED _____ 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES OF PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (FOR GOVT. CLAIMS, SEE BACK) ☐ YES ☐ NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. Rsvd for NUCC Use
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.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33 BILLING PROVIDER INFO & PH # ( ) a. NPI b.	

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM 1500 (02-12)

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 TRICARE 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, 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 TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE 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 TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE 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, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary physician's direct supervision by his/her employee, 2) they must be an integral , although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE 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, other civilian or military (refer to 5 USC 5536). For Black -Lung claims, I 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 by subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, 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 TRICARE 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 TRICARE/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 TRICARE.

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 0938-1197. 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, 7500 Security Boulevard, Attn: PRA Records Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address if for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 1

DATA FIELD: COVERAGE INDICATOR **1500** OR **DDE** NR

Definition:

Instruction: Place an "X" in the box for "Medicaid" if billing for services provided to a Medicaid beneficiary,

OR

Place an "X" in the box for "OTHER" if billing for mental health rehabilitation services provided through the Child Behavioral Health Services (CBHS) to a child who is not eligible for Medicaid.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 1a

DATA FIELD: INSURED'S I.D. NUMBER **1500** R **DDE** R

Definition: The twelve 12-digit number that designates the beneficiary's Medicaid eligibility number.

Instruction: Print or type the beneficiary's identification number and person number.

Field Characteristics: It is a 12 position numeric field.

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 2

DATA FIELD: PATIENT'S NAME
(Last Name, First Name, Middle Initial)

1500	R	**DDE**	R

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

Instruction: Print or type the beneficiary's name; last name must be entered first.

Field Characteristics: It is an Alpha field.

Values:

Notes:

EFFECTIVE: January 13, 2015 **FORM LOCATOR** 3

DATA FIELD:	PATIENT'S BIRTHDATE	**1500**	R	**DDE**	R
	SEX	**1500**	R	**DDE**	NR

Definition: The patient's date of birth. The patient's sex.

Instruction: Print or type the beneficiary's date of birth using the month, day, year format (MMDDYYYY). Example, September 10, 2003 is entered as 09102003.

Print or type an "X" in the appropriate box that identifies the sex of the beneficiary.

Field Characteristics:	**Birthdate**	**Sex**
	It is a 8 position numeric field.	It is a 1 position alpha field.

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 4

DATA FIELD: INSURED'S NAME
(Last Name, First Name, Middle Initial)

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 5

DATA FIELD: PATIENT'S ADDRESS (No., Street) **1500** R **DDE** NR

Definition: The location of the beneficiary's residence.

Instruction: Print or type the beneficiary's complete home address.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 6

DATA FIELD: PATIENT RELATIONSHIP TO INSURED **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 7

DATA FIELD: INSURED'S ADDRESS (No., Street) **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 8

DATA FIELD: RESERVED FOR NUCC USE **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 9

DATA FIELD: OTHER INSURED'S NAME
(Last Name, First Name, Middle Initial)

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 9a

DATA FIELD: OTHER INSURED'S POLICY OR GROUP NUMBER

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 9b

DATA FIELD: RESERVED FOR NUCC USE **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 9c

DATA FIELD: RESERVED FOR NUCC USE **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 9d

DATA FIELD: INSURANCE PLAN NAME OR PROGRAM NAME

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: January 13, 2015 **FORM LOCATOR** 10abc

DATA FIELD: IS PATIENT'S CONDITION RELATED TO: **1500** R **DDE** R

a. EMPLOYMENT?
b. AUTO ACCIDENT?
c. OTHER ACCIDENT?

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

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

Field Characteristics: It is a 1 position alpha field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 10d

DATA FIELD: CLAIM CODES (Designated for NUCC) **1500** OR **DDE** OR

Definition: A carrier code is a three (3)-digit code assigned to identify the beneficiary's other insurance carrier.

Instruction: Print or type the three (3)-digit health insurance carrier code.

Field Characteristics: It is a 9 position numeric field.

Values:

Notes:

1. A list of carrier codes is included in the Appendices "C and 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 (3) carrier codes may be entered in this form locator.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 11

DATA FIELD: INSURED'S POLICY GROUP OR FECA NUMBER

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 11a

DATA FIELD: INSURED'S DATE OF BIRTH/SEX **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 11b

DATA FIELD: OTHER CLAIM ID (Designated by NUCC) **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 11c

DATA FIELD: INSURANCE PLAN NAME OR PROGRAM NAME

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 11d

DATA FIELD: IS THERE ANOTHER HEALTH BENEFIT PLAN?

1500	R	**DDE**	R

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

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

Field Characteristics: It is a 1 position alpha field.

Values:

Notes: If field 10d is completed, then mark "YES".

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 12

DATA FIELD: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

1500	R	**DDE**	NR

Definition: The beneficiary or authorized person signs and dates the 1500 form. This authorizes the release of any medical or other information necessary to process the claim.

Instruction: The beneficiary or authorized person must sign and date the 1500 form. Using date format MMDDYY. The patient's signature is waived if "Beneficiary signature on file" is entered in this field.

Field Characteristics: It is an alpha-numeric field.

Values:

Notes:

1. If this field is left blank, then the claim form will be returned.
2. If the patient’s signature is unobtainable, refer to N.J.A.C. 10:49 (Administration), Chapter 1 of the Provider Manual.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 13

DATA FIELD: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 14

DATA FIELD: DATE OF CURRENT ILLNESS OR INJURY OR PREGNANCY (LMP)

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 15

DATA FIELD: OTHER DATE **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 16

DATA FIELD: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 25, 2007 **FORM LOCATOR** 17

DATA FIELD: NAME OF REFERRING PROVIDER OR OTHER SOURCE

1500 OR **DDE** NR

Definition: The name of the referring or ordering provider who referred or ordered the service(s) or supply(s) on the claim.

Instruction: Print or type the name of the referring or ordering provider.

Field Characteristics: Alpha

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 17a

DATA FIELD: UNLABELED **1500** OR **DDE** OR

Definition: The payer assigned non-NPI ID number of the ordering provider.

Instruction: Print or type "G2" in the first small box for this form locator. The presence of the G2 indicates that the ID Number being reported in the second box for this form locator is the provider's seven (7) digit Medicaid provider number. If a value of "G2" is not reported in this field, any provider identifier reported will be ignored.

Print or type the seven (7) digit New Jersey Medicaid provider number for this provider in the second box for this form locator. The New Jersey Medicaid provider number will not be recognized unless the qualifier of "G2" is reported in the qualifier field to the immediate right of 17a.

Field Characteristics: It is a 2 position alpha\numeric field plus 7 position numeric field.

Values:

Notes:

1. Use the individual provider number for all NJ Medicaid participating and non-participating providers.
2. For Mental Health Rehabilitation services it is not necessary to complete this field.
3. For DDE claims just enter 7-digit number

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 17b

DATA FIELD: NPI **1500** OR **DDE** OR

Definition: The NPI number refers to the HIPAA National Provider Identifier number.

Instruction: If a referring or ordering physician is required on the claim, you must print or type the NPI number of the referring or ordering provider.

Field Characteristics: It is a 10 position numeric field.

Values:

Notes: For Mental Health Rehabilitation services it is not necessary to complete this field.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 18

DATA FIELD: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

1500 NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: May 19, 2015 **FORM LOCATOR** 19

DATA FIELD: ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

1500 OR **DDE** OR

Definition:
1. Anesthesia administration time
2. Patient responsibility amount

Instruction:
1. Print or type the length of time used for administering anesthesia.
2. Use to report a "Patient Responsibility Amount" when submitting a claim for reimbursement of a co-payment, co-insurance or deductible and/or primary insurance denied charges.

Field Characteristics:

Values:

Notes:
1. For anesthesia, enter the length of anesthesia administration time. Example: one (1) hour.
2. Refer to Newsletter Vol. 21 No. 1.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 20

DATA FIELD: OUTSIDE LAB? $CHARGES **1500** OR **DDE** NR

Definition: Indicates whether there were any outside lab charges.

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

Field Characteristics: It is a 1 position alpha field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 21

DATA FIELD: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line blow (24E)

1500	R	**DDE**	R

Definition: Version indicator.
The diagnosis code(s).

Instruction: Print or type the version indicator (see values below).
Print or type the diagnosis code(s), which describe the diagnosis.

Field Characteristics: It is a 7 position alpha-numeric field.

Values: 9 = ICD9
0 = ICD10

Notes:
- Print or type the diagnosis code.
- Do not enter any additional leading or trailing zeros to the code.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 22

DATA FIELD: RESUBMISSION CODE/ORIGINAL REF. NO. **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 23

DATA FIELD: PRIOR AUTHORIZATION NUMBER **1500** OR **DDE** OR

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

Instruction: If applicable, enter the PA number for the service provided.

Field Characteristics: It is a 10 position numeric field.

Values:

Notes:

EFFECTIVE: August 6, 2007 **FORM LOCATOR** 24A

DATA FIELD: UPPER-HORIZONTAL SHADED AREA **1500** OR **DDE** OR

Definition: NDC reporting on physician-administered and Medicare Part-B covered drugs.

Instruction: Print or type the qualifier "N4" followed by the 11 digit NDC number, followed by three spaces, followed by the two position qualifier identifying the "unit of measure". This information should correspond to the HCPCS code reported in form locator 24D.

Field Characteristics: It is a 26 position alpha-numeric field.

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 24A

DATA FIELD: DATE(S) OF SERVICE **1500** R **DDE** R

Definition: The start and end of services.

Instruction: Print or type the "from" and "to" dates of service to which the claim applies using the month, day and year format (MMDDYY).

Field Characteristics: It is a 12 position numeric field.

Values:

Notes:

EFFECTIVE: April 28, 2025 **FORM LOCATOR** 24B

DATA FIELD: PLACE OF SERVICE **1500** R **DDE** R

Definition: The place where services were rendered.

Instruction: Print or type the place that the service was rendered for each procedure performed.

Field Characteristics: It is a 2 position numeric field.

Values:
01 – Pharmacy
02 – Telehealth is Provided in Other Than a Patient's Home
03 – School
04 – Homeless shelter
05 – Indian Health Service Free-standing facility
06 – Indian Health Service Provider-based facility
07 – Tribal 638 Free-standing facility
08 – Tribal 638 Provider-based facility
09 – Prison/correctional facility
10 – Telehealth Provided in a Patient's Home
11 – Office
12 – Home
13 – Assisted living facility
14 – Group Home
15 – Mobile unit
16 – Temporary Lodging
17 – Walk – in retail health clinic
18 – Place of employment – worksite
19 – Outpatient Hospital – Off Campus
20 – Urgent Care facility
21 – Inpatient Hospital
22 – Outpatient Hospital – On Campus
23 – Emergency Room – Hospital
24 – Ambulatory Surgical Center
25 – Birthing Center
26 – Military Treatment Facility
27 -- Outreach Site/Street
31 – Skilled Nursing Facility
32 – Nursing Facility
33 – Custodial Care Facility
34 – Hospice
41 – Ambulance – Land

42 – Ambulance – Air or Water
49 – Independent Clinic
50 – Federally Qualified Health Center
51 – Inpatient Psychiatric Facility
52 – Psychiatric Facility Partial Hospitalization
53 – Community Mental Health Center
54 – Intermediate Care Facility/Mentally Retarded
55 – Residential Substance Abuse Treatment Facility
56 – Psychiatric Residential Treatment Center
57 – Non-Residential Substance Abuse Treatment Facility
60 – Mass Immunization Center
61 – Comprehensive Inpatient Rehabilitation Facility
62 – Comprehensive Outpatient Rehabilitation Facility
65 – End Stage Renal Disease Treatment Facility
71 – State or Local Public Health Clinic
72 – Rural Health Clinic
81 – Independent Laboratory
99 – Other Unlisted Facility

Notes:

EFFECTIVE: June 25, 2007 **FORM LOCATOR** 24C

DATA FIELD: EMG **1500** NR **DDE** NR

Definition: Emergency services.

Instruction: New Jersey Medicaid does not require the completion of this field.

Field Characteristics: It is a 1 position alpha field.

Values:

Notes:

EFFECTIVE: June 25, 2007 **FORM LOCATOR** 24D

DATA FIELD: PROCEDURES, SERVICES, OR SUPPLIES **1500** R **DDE** R

Definition: The procedure code is a five (5) digit code for all medical services that defines the service delivered to the patient.

Instruction: Print or type the appropriate five (5) digit CPT or HCPCS procedure code and up to four two-digit modifiers, if applicable, for each service provided.

Field Characteristics: It is a 13 position alpha-numeric field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 24E

DATA FIELD: DIAGNOSIS POINTER **1500** R **DDE** R

Definition: The diagnosis pointer refers to the line number from Form Locator 21 that relates to the reason the service (s) was performed

Instruction: Print or type the reference alpha (pointer) that corresponds with the diagnosis code in Form Locator 21 to relate the date of service and the procedures performed to the related diagnosis codes.

Field Characteristics: It is a 1 to 4 position alpha field.

Values:

Notes:

EFFECTIVE: December 2011 **FORM LOCATOR** 24F

DATA FIELD: $ CHARGES **1500** R **DDE** R

Definition: The usual and customary charge(s).

Instruction: Print or type the usual and customary charge for each service or procedure performed.

Field Characteristics: It is a 9 position numeric field.

Values:

Notes:

- This amount must reflect the total charge for the claim service detail line.
- Do not use decimal points or a dollar sign.
  Example: $25.00 is entered as 2500.
- For DDE you must use decimal point.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 24G

DATA FIELD: DAYS OR UNITS **1500** R **DDE** R

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

Instruction: Print or type the number of service units.

Field Characteristics: It is a 4 position numeric field.

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 24H

DATA FIELD: EPSDT/FAMILY PLANNING **1500** OR **DDE** OR

Definition: The EPSDT/Family Plan identifies certain services that may be covered under Medicaid/NJ FamilyCare program.

Instruction:

1. If the service delivered is the result of an EPSDT referral, enter the response in the shaded portion of the field as follows: Y for “YES” or N for “NO”.

2. Effective August 5, 2019, If the service is FAMILY PLANNING related, enter the response in the unshaded portion of the field as follows: Y for “YES” and if not FAMILY PLANNING leave blank.

Field Characteristics: It is a 1 position alpha field.

Values:

Notes:

Effective August 5, 2019, Family Planning providers must request payment from other insurers, including Medicare for a Medicare-covered service, prior to submitting family planning claims to the Medicaid/NJFC program. For additional information, please see Newsletter Vol. 29 No. 14.

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 24I

DATA FIELD: ID Qualifier **1500** OR **DDE** NR

Definition: The qualifier will indicate the non-NPI number being reported.

Instruction: Leave blank.

Field Characteristics: Print or type "G2" in the shaded area to indicate that the non-NPI number being reported in Field 24J is a Medicaid Provider Number. Failure to code a value of “G2” in this field will result in any number entered in Form Locator 24J to be ignored.

Values: It is a 2 position alpha-numeric field.

Notes: **If this is a group provider billing, this field is required.**

EFFECTIVE: June 25, 2007 **FORM LOCATOR** 24J

DATA FIELD: RENDERING PROVIDER ID. # **1500** OR **DDE** OR

Definition: The non-NPI number of the rendering provider refers to the payer assigned unique identifier of the professional.

Instruction: Print or type the New Jersey Medicaid Provider Number of the rendering provider in the shaded area and the NPI number in the unshaded area. These fields only need to be completed when the rendering provider is different than the billing provider identifiers reported in Form Locators 33a, and 33b.

Field Characteristics: The New Jersey Medicaid Provider Number is a 7 position numeric field and the NPI Number is a 10 position numeric field.

Values:

Notes: **If this is a group provider billing, this field is required.**

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 25

DATA FIELD: FEDERAL TAX ID NUMBER **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 26

DATA FIELD: Patient's Account No. **1500** OR **DDE** OR

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

Instruction: Print or type up to sixteen (16) alpha or numeric characters of the provider's internal account number for the beneficiary.

Field Characteristics: It is a 16 position alpha-numeric field.

Values:

Notes: This information will be printed on the RA and may help with the provider account reconciliation.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 27

DATA FIELD: ACCEPT ASSIGNMENT? **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 28

DATA FIELD: TOTAL CHARGE **1500** R **DDE** R

Definition: The sum of charges for all the detail lines.

Instruction: Add the amounts from each claim service detail line in field #24F, "charges" and print or type the total.

Field Characteristics: It is a 9 position numeric field.

Values:

Notes: Do not use decimal points or dollar signs.

For DDE you must use decimal point.

EFFECTIVE: June 14, 2001 **FORM LOCATOR** 29

DATA FIELD: AMOUNT PAID **1500** OR **DDE** OR

Definition: Amount paid by other sources.

Instruction: Print or type any amount already paid by sources other than Medicare.

Field Characteristics: It is a 9 position numeric field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 30

DATA FIELD: Rsvd for NUCC Use **1500** NR **DDE** NR

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 31

DATA FIELD: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS

1500	R	**DDE**	R

DATA ELEMENT:

Definition: An authorized signature certifying that the information entered on the claim is in conformance with the instruction on the back of the 1500.

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

Field Characteristics: It is an alpha-numeric field.

Values:

Notes: No stamped, computer-generated or facsimile signatures will be accepted. The date must be on or after the last date of service on the claim.

For DDE claims, type your name and today's date.

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 32

DATA FIELD: SERVICE FACILITY LOCATION INFORMATION

1500 NR **DDE** NR

Definition: Where the services were rendered.

Instruction: Print or type the name and address of the facility where service were rendered, if other than the provider's office or the beneficiary's home.

Field Characteristics: It is an alpha-numeric field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 32a

DATA FIELD: NPI **1500** NR **DDE** NR

Definition: The NPI number refers to the HIPAA National Provider Identifier Number.

Instruction: New Jersey Medicaid does not require the completion of this field.

Field Characteristics: It is a 10 position numeric field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 32b

DATA FIELD: UNLABELED **1500** NR **DDE** NR

Definition: The non-NPI ID number of the service facility refers to the payer assigned unique identifier of the facility.

Instruction: New Jersey Medicaid does not require the completion of this field.

Field Characteristics: It is a 9 position numeric-alpha field.

Values:

Notes:

EFFECTIVE: January 1, 2013 **FORM LOCATOR** 33

DATA FIELD: BILLING PROVIDER INFO & PHONE # **1500** R **DDE** NR

Definition: The billing provider's name, address, and phone number.

Instruction: Print or type the billing provider's name, address, and telephone number.

Field Characteristics: It is an alpha-numeric field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 33a

DATA FIELD: NPI **1500** R **DDE** R

Definition: NPI number of the billing provider.

Instruction: Print or type the NPI number of the billing provider in the unshaded area.

Field Characteristics: It is a 10 position numeric field.

Values:

Notes:

EFFECTIVE: February 4, 2014 **FORM LOCATOR** 33b

DATA FIELD: UNLABELED **1500** R **DDE** NR

Definition: The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.

Instruction: Print or type “G2” in the first two positions of this field. The presence of the G2 indicates that the ID Number being reported is the billing provider’s seven (7) digit Medicaid provider number. If a value of “G2” is not reported in this field, any provider identifier reported will be ignored.

Print or type the seven (7) digit New Jersey Medicaid provider number for the billing provider immediately following the “G2”

Field Characteristics: It is a 9 position alpha-numeric field.

Values:

Notes: For DDE claims, this field is populated with Provider Number that was used to log into the website.

6.2 Report And Claim For EPSDT/HEALTHSTART Screening And Related Procedures (MC-19)

The following are form locator instructions for completing an EPSDT/HealthStart claim form. This form is to be used whenever an EPSDT or HealthStart examination is performed.

Forward completed MC-19 claim forms to:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

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

REPORT AND CLAIM FOR EPSDT/HEALTHSTART SCREENING AND RELATED PROCEDURES

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, city, state, ZIP code)

Telephone No.

5. PATIENT'S SEX
MALE ☐ FEMALE ☐

6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. PATIENT'S MEDICAID I.D. NO. PERSON No.

9. OTHER HEALTH INSURANCE COVERAGE YES ☐ NO ☐
Enter Name of Policyholder and Plan Name and Address and Policy Number

10. RACE
WHITE ☐ ASIAN ☐
BLACK ☐ OTHER ☐
HISPANIC ORIGIN YES ☐ NO ☐

11. REFERRING PHYSICIAN OR OTHER SOURCE
(Please include Provider ID Number)

12. PATIENT'S OR AUTHORIZED PERON'S SIGNATURE (READ BACK BEFORE SIGNING)
I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy.
Relationship: Check if other than patient
☐ Authorized Rep. ☐ Relative ☐ Other

SIGNED DATE

13. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE
YES ☐ NO ☐ CHARGES _____

13A. PRIOR AUTHORIZATION NUMBER:

14.A. DATE OF SERVICE FROM TO	B. *PLACE OF SERVICE	C. *T.O.S.	D. PROCEDURE CODE (IDENTIFY)	E. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services or Circumstances)	F. DIAGNOSIS CODE	G. DAYS OR UNITS	H. CHARGES	I. FAM PLAN	J. LEAVE BLANK

16. TOTAL CHARGE | 17. AMOUNT PAID | 18. BALANCE DUE

15. ASSESSMENTS: Indicate results (1-4) or No Abnormality Found (Unclothed Physical Only) in first column; If abnormal, also indicate 5 or 6 in second column.

HEIGHT ____ WEIGHT ____ HEAD CIRC. ____

1=Normal
2=Abnormal - Treatment not required
3=Abnormal - Treatment by Screening Provider
4=Abnormal - Referral Other Provider
5=New Condition
6=Prior Condition

A. UNCLOTHED PHYSICAL

No Abnormality Found	( )	
Cardiac	( )	( )
Orthopedic	( )	( )
Neurologic	( )	( )
Genito-urinary	( )	( )
ENT/Respiratory	( )	( )
Endocrine	( )	( )
Other	( )	( )

If other, indicate body system _____

B. VISION SCREEN	( )	( )
C. HEARING SCREEN	( )	( )
D. DENTAL SCREEN	( )	( )
E. NUTRITION	( )	( )
F. GROWTH	( )	( )
G. BEHAVIOR/SOCIAL	( )	( )
H. DEVELOPMENT	( )	( )

19. LABORATORY: Indicate results (1-6)
1=Normal
2=Abnormal - Treatment not required
3=Abnormal - Treatment by Screening Provider
4=Abnormal - Referral Other Provider
5=Not Done
6=Results Pending

A. Urinalysis	( )
B. Hemoglobin or Hematocrit	( )
C. Sickle Cell	( )
D. Tuberculin	( )
E. Lead Screening	( )

20. IMMUNIZATIONS STATUS: Indicate status (1-4)
1=Too Young for Shot
2=Complete for Age
3=Given - Incomplete
4=Not Given - Incomplete

A. DTP or DT or Td	( )
B. Oral Polio or IPV	( )
C. MMR	( )
D. haem.b	( )

21. Anticipatory Guidance/Health Education Given? Yes ☐ No ☐

22. Child Will Be Under My Continued Care? Yes ☐ No ☐

23. Is Child Receiving WIC? Yes ☐ Referred ☐ Not Indicated ☐

24. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, & ZIP CODE

TELEPHONE NO.

25. SIGNATURE OF PHYSICIAN OR SUPPLIER
(I certify that the statements on the reverse apply to this bill and are made a part hereof.)

SIGNED _____
MD ☐ DO ☐

DATE

26. SHCF No.

27. GSHP Referral No.

MC-19 (REV. 9/91) * SEE REVERSE Medicaid Part 1 of 2

Rev. May 2025

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EFFECTIVE: March 2010 **FORM LOCATOR** 1

DATA FIELD: PATIENT'S NAME **MC-19** R **DDE** R

Definition: The full name of the beneficiary to whom service is being rendered.

Instructions: Print or type the beneficiary's name.

Field Characteristics:
1 Field
1 Line
20 Positions
Alpha-Numeric

Values:

Notes: You must put the beneficiary's first name first or your claim will be denied for name mismatch.

EFFECTIVE: March 2010 **FORM LOCATOR** 2

DATA FIELD: PATIENT'S DATE OF BIRTH **MC-19** R **DDE** R

Definition: The birth date of the beneficiary.

Instructions: Print or type the beneficiary's date of birth in month, day, and year sequence (MMDDYY).

Example: November 5, 1995 is entered as 110595

Field Characteristics:
1 Field
1 Line
6 Positions
Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 3

DATA FIELD: INSURED'S NAME **MC-19** NR **DDE** NR

Definition:

Instructions: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 4

DATA FIELD: PATIENT'S ADDRESS **MC-19** R **DDE** NR

Definition: The location of the beneficiary's residence and telephone number.

Instructions: Print or type the beneficiary's complete address and telephone number including area code.

Field Characteristics:
3 Fields
2 Lines
50 Positions
Alpha-Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 5

DATA FIELD: PATIENT'S SEX **MC-19** R **DDE** NR

Definition: The gender of the beneficiary.

Instructions: Check the appropriate box to indicate the beneficiary's sex.

Field Characteristics:
1 Field
1 Line
1 Position
Alpha-Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 6

DATA FIELD: PATIENT'S MEDICARE/CHAMPUS NO. **MC-19** NR **DDE** NR

Definition: The number that designates the patient's Medicare/CHAMPUS case number.

Instructions: Copy the patient's ID Number (Health Insurance Claim Number) as printed on the Medicare Health Insurance Card when the patient is covered by both Medicare and Medicaid. Copy the patient's CHAMPUS number, if applicable.

Field Characteristics:
1 Field
1 Line
12 Positions
Alpha-Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 7

DATA FIELD: PATIENT'S RELATIONSHIP TO INSURED **MC-19** NR **DDE** NR

Definition:

Instructions: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 8

DATA FIELD: PATIENT'S MEDICAID I.D. NO. **MC-19** R **DDE** R

Definition: The twelve (12) digit number that designates the beneficiary's Medicaid case number.

Instructions: Print or type the beneficiary's MEI (Medicaid Eligibility Identification) Case Number and Person Number.

Field Characteristics:
1 Field
1 Line
12 Positions
Numeric

Values:

Notes: For newborns use MEI (Medicaid Eligibility Identification) Case number and Person Number of the mother for up to 60 days after the date of birth of the newborn (thru last day of month in which the 60th day occurs).

Providers can obtain the Beneficiary's Medicaid Identification Number by verifying eligibility through eMEVS, MEVS or REVS.

EFFECTIVE: March 2010 **FORM LOCATOR** 9

DATA FIELD: OTHER HEALTH INSURANCE/NO FAULT AUTO COVERAGE **MC-19** OR **DDE** OR

Definition: Indicates if the beneficiary has other health care coverage. Carrier Code is a three digit code assigned to identify beneficiary's other insurance carrier.

Indicates whether service(s) is covered by No Fault Auto Coverage.

Instructions: Check the appropriate block to indicate whether the beneficiary has other health insurance coverage.

Field Characteristics: 1 Field

Values: Yes
No

Notes:

1) If indicator is "Yes" then you must only enter the appropriate three digit carrier code in the Form Locator (9).

2) A list of health insurance carrier identification codes is included in Appendices "C and D" of this Billing Supplement.

3) When a Medicaid beneficiary has other health insurance coverage, the provider must first bill the other health insurance carrier. For exceptions to this rule, see N.J.A.C. 10:49. A copy of the notice of denial of the explanation of benefits from the other carrier must be attached to the Medicaid claim. In Form Locator (17) enter any payment amount received from the other insurance carrier, unless total payment was from the Medicare program.

EFFECTIVE: March 2010 **FORM LOCATOR** 10

DATA FIELD: RACE **MC-19** R **DDE** R

Definition: The ethnicity of the patient.

Instructions: Check the appropriate box to indicate beneficiary's race. Also, check the appropriate box to indicate whether or not the patient is of Hispanic origin.

Field Characteristics:

Values:

Notes:

EFFECTIVE: January 2013 **FORM LOCATOR** 11

DATA FIELD: REFERRING PHYSICIAN OR OTHER SOURCE

MC-19 OR **DDE** OR

Definition: The name and seven (7) digit Medicaid number of the physician other than the attending physician.

Instructions: Print or type the name of the referring physician or practitioner, if applicable. The seven-digit Medicaid provider number of the referring physician or practitioner must also be entered.

Field Characteristics:
1 Field
7 Positions
Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12

DATA FIELD: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE **MC-19** R **DDE** NR

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

Instructions: The patient or authorized representative must sign and enter the date in MMDDYY sequence. If the form is not signed by the patient, the appropriate box must be checked. The patient's signature is waived if "Recipient Signature on File" is entered in this space.

Field Characteristics:
1 Field
1 Line
6 Positions
Numeric

Values: Relationship: Check if other than patient

Auth. Rep
Relative
Other

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 I of the Provider Manual for procedures to follow for acceptable alternate signatures.

3) The patient or authorized representative signature, authorizes the release of information and payment requests.

EFFECTIVE: March 2010 **FORM LOCATOR** 13

DATA FIELD: WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? **MC-19** OR **DDE** OR

Definition: Indicates whether work was performed in or out of your office.

Instructions: Check the appropriate block to indicate whether laboratory work was analyzed by the provider or outside of the provider's office. If laboratory work was not performed, leave this field blank.

Field Characteristics:

Values:

Notes: If yes, enter charges.

EFFECTIVE: March 2010 **FORM LOCATOR** 13A

DATA FIELD: PRIOR AUTHORIZATION NUMBER **MC-19** NR **DDE** NR

Definition: The authorization number granted to a provider to render specified services within certain parameters.

Instructions: Leave blank.

Field Characteristics:

Values:

Notes: PA is not required for Pediatric HealthStart.

EFFECTIVE: March 2010 **FORM LOCATOR** 14A

DATA FIELD: DATE OF SERVICE **MC-19** R **DDE** R

Definition: The month, day, and year service(s) was performed.

Instructions: Print or type the date of service in month, day, and year (MMDDYY) format.

Example: January 5, 2011 is entered as 010501.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2023 **FORM LOCATOR** 14B

DATA FIELD: PLACE OF SERVICE **MC-19** R **DDE** R

Definition: The place where services were performed.

Instructions: Print or type the place of service for each service performed.

Field Characteristics:

Values:
0 = Emergency Room
1 = Doctor's Office
2 = Telehealth is Provided in Other Than a Patient’s Home
3 = Inpatient Hospital
4 = Boarding Home
5 = Nursing Facility
6 = Independent Laboratory
7 = Outpatient Hospital
8 = Clinic
9 = Other
10 = Telehealth Provided in a Patient’s Home

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 14C

DATA FIELD: TYPE OF SERVICE (TOS) **MC-19** R **DDE** R

Definition: A broad classification of services used in conjunction with a procedure code to uniquely define a service.

Instructions: Select the appropriate code from the list below.

Field Characteristics:

Values: Type of Service Code:

1 = Medical Care
2 = Surgery
3 = Consultation
4 = Diagnostic X-Ray
5 = Diagnostic Laboratory
6 = Radiation Therapy
7 = Anesthesia
8 = Assistance at Surgery
9 = Other Medical Service
0 = Blood or Packed Red Cells
A = Used DME
M = Alternate Payment for Maintenance Dialysis
Y = Second Opinion on Elective Surgery
Z = Third Opinion on Elective Surgery

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 14D

DATA FIELD: PROCEDURE CODE **MC-19** R **DDE** R

Definition: The procedure code is a five (5) digit code for all medical procedures covered by Medicaid. The modifier is a two (2) digit explanation code added to the procedure code.

Instructions: Print or type the appropriate five (5) digit HCPCS procedure code and two (2) digit modifier (if applicable) for each service provided. A list of eligible HCPCS codes for the New Jersey Medicaid Program can be found in the Medicaid Provider Manual.

Field Characteristics:
1 Field
6 Lines
7 Positions
Alpha-Numeric

Values:

Notes:

1. For New Jersey Medicaid purposes, there are five (5) positions for each procedure code; two (2) positions for each modifier. The modifier code elaborates, specifies, and/or clarifies the description of a beneficiary's medical treatment/service and/or its pricing formula; it is used for refining and defining the actual pricing of the medical treatment/process/program.

2. The procedure codes for EPSDT or pediatric HealthStart examinations **must always** appear on the first line of the claim form. Other related services (i.e., immunizations) are billed on subsequent lines if the service is provided on the same day as the EPSDT or pediatric HealthStart examination. If this procedure is not followed all subsequent lines of the claim will be denied.

   If you are **NOT** certified as a HealthStart pediatric provider, you must use the "EP" modifier for all EPSDT procedure codes except W9820 or your claims will be denied with **ERROR CODE 214-Provider Not Eligible for HealthStart**.

   Routine office visits, annual health maintenance examinations, or maternity-related HealthStart services must be billed on the CMS-1500. Do not use the MC-19.

   EPSDT services must be billed within 30 days from the date of service.

   HealthStart services must be billed within 90 days from the date of service.

EFFECTIVE: March 2010 **FORM LOCATOR** 14E

DATA FIELD: FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN

MC-19	R	**DDE**	NR

Definition: The explanation of the procedure to be performed.

Instructions: Give a brief description of the service(s) requested or provided.

Field Characteristics:
1 Field
6 Lines
20 Positions
Alpha-Numeric

Values:

Notes:

EFFECTIVE: January 1, 2014 **FORM LOCATOR** 14F

DATA FIELD: DIAGNOSIS CODE **MC-19** R **DDE** R

Definition: The coding structure for diagnosis as defined by the Centers for Medicare and Medicaid Services.

Instructions: Print or type the valid diagnosis code.

Field Characteristics:

Values:

Notes:
- Print or type the diagnosis code.
- Do not add any additional leading or trailing zeros to the code.

EFFECTIVE: March 2010 **FORM LOCATOR** 14G

DATA FIELD: DAYS OR UNITS **MC-19** R **DDE** R

Definition: The number of days, visits, units or treatments requested by the provider for each procedure code.

Instructions: Print or type the number of units of service for each procedure code.

Field Characteristics:
1 Field
6 Lines
4 Positions
Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 14H

DATA FIELD: CHARGES **MC-19** R **DDE** R

Definition: The provider's usual and customary fee for each procedure requested.

Instructions: Print or type the provider's usual and customary charge for each procedure.

Field Characteristics:

Values:

Notes: **Example:** Four (4) units of service at $5.00 per unit would be shown as 2000. Do not use dollar signs, decimals, or spaces.

This amount must reflect the total charge for all units of service.

EFFECTIVE: March 2010 **FORM LOCATOR** 14I

DATA FIELD: CHECK IF FAMILY PLANNING **MC-19** OR **DDE** OR

Definition: Indicates if services were for family planning.

Instructions: Check this column for each physician service related to "Family Planning.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 14J

DATA FIELD: LEAVE BLANK **MC-19** OR **DDE** OR

Definition: The seven (7) digit Medicaid provider number of the servicing physician.

Instructions: Print or type the servicing provider's seven (7) digit Medicaid number.

Field Characteristics:

Values:

Notes: Not required for clinics.

Required for Group Practices.

EFFECTIVE: March 2010 **FORM LOCATOR** 15

DATA FIELD: ASSESSMENTS **MC-19** R **DDE** R

Definition: The results of the examination.

Instructions: Height, Weight, Head Circ: Enter the child's height and weight. If the child is under the age of two, enter the head circumference.

Field Characteristics:
1 Field
1 Line
3 Positions
Alpha-Numeric

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15A

DATA FIELD: UNCLOTHED PHYSICAL **MC-19** R **DDE** R

Definition: The results of the well baby examination.

Instructions: Print or type the results of the unclothed physical examination. If no abnormalities are found, enter the code (1) in the block "No Abnormality Found." If any abnormality is identified, indicate the results of each body system in the first column using the appropriate code.

When an abnormality is identified (results 2, 3, or 4), a code must be entered in the second column to indicate whether this is a new or prior condition (i.e. if reference is greater than one (1) indicate if the condition is a new or prior). If there is an abnormality and you do not enter a code in both columns your claim will be denied.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal-Treatment not required
3 = Abnormal-Treatment by Screening Provider
4 = Abnormal-Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes: A value must be entered for each section of the assessment results (indicated by the letters A through H), for each type of laboratory test (Form Locator 19), and for each type of immunization (Form Locator 20). Since all components of the examination must be completed, do not leave the vision, dental or hearing sections of the form blank because the child is an infant. The purpose of these sections is to record that an age appropriate assessment has been performed as part of this general examination. This does not imply that a formal standardized testing has been performed.

If the child is uncooperative, observe the child as best you can and enter values in A-H. Keep detailed, accurate notes of the examination in your personal patient history file. You must enter a value code in A-H or your claim will be denied.

EFFECTIVE: March 2010 **FORM LOCATOR** 15B

DATA FIELD: VISION SCREEN **MC-19** R **DDE** R

Definition: The results from the vision examination.

Instructions: Indicate the results of the vision screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15C

DATA FIELD: HEARING SCREEN **MC-19** R **DDE** R

Definition: The results of the hearing examination.

Instructions: Indicate the results of the hearing screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15D

DATA FIELD: DENTAL SCREEN **MC-19** R **DDE** R

Definition: The results of the dental examination.

Instructions: Indicate the results of the dental screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15E

DATA FIELD: NUTRITION **MC-19** R **DDE** R

Definition: The results of the nutritional examination.

Instructions: Indicate the results of the nutritional screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15F

DATA FIELD: Growth **MC-19** R **DDE** R

Definition: The results of the growth examination.

Instructions: Indicate the results of the growth screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15G

DATA FIELD: BEHAVIOR/SOCIAL **MC-19** R **DDE** R

Definition: The results of the behavioral/social examination.

Instructions: Indicate the results of the behavioral/social screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 15H

DATA FIELD: DEVELOPMENT **MC-19** R **DDE** R

Definition: The results of the developmental examination.

Instructions: Indicate the results of the developmental screening in the first column using the appropriate code.

When an abnormality is identified a code must be entered in the second column to indicate whether this is a new or prior condition. If there is an abnormality and you do not enter a code in both columns, your claim will be denied (i.e., if reference is greater than one (1), indicate if the condition is a new or prior condition.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not Required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = New Condition
6 = Prior Condition

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 16

DATA FIELD: TOTAL CHARGE **MC-19** R **DDE** R

Definition: The sum of charges for all detail lines.

Instructions: Add the amounts from each claim service detail line in 14H and enter the TOTAL in 16.

Field Characteristics:

Values:

Notes: **Example:** Four (4) units of service at $5.00 per unit would be shown at 2000. Do not use dollar signs, decimals, or spaces.

This amount must reflect the total charge for all units of service.

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 17

DATA FIELD: AMOUNT PAID **MC-19** OR **DDE** OR

Definition: Amount paid by other insurance.

Instructions: Print or type any amount already paid by another insurance other than Medicare.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 18

DATA FIELD: BALANCE DUE **MC-19** R **DDE** R

Definition: The total amount due after the other insurance payment.

Instructions: Print or type the balance due from Medicaid (Field 16 less Field 17).

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 19

DATA FIELD: LABORATORY **MC-19** R **DDE** R

Definition: The results of the laboratory examination.

Instructions: Print or type the results of the laboratory results.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = Not Done
6 = Results Pending

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 19A

DATA FIELD: Urinalysis **MC-19** R **DDE** R

Definition: The results of the urine examination.

Instructions: Print or type the results of the laboratory results.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = Not Done
6 = Results Pending

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 19B

DATA FIELD: Hemoglobin or Hematocrit **MC-19** R **DDE** R

Definition: The results of the hemoglobin or hematocrit examination.

Instructions: Print or type the results of the laboratory results.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = Not Done
6 = Results Pending

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 19C

DATA FIELD: Sickle Cell **MC-19** R **DDE** R

Definition: The results of the sickle cell examination.

Instructions: Print or type the results of the laboratory results.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = Not Done
6 = Results Pending

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 19D

DATA FIELD: Tuberculin **MC-19** R **DDE** R

Definition: The results of the tuberculin examination.

Instructions: Print or type the results of the laboratory results.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = Not Done
6 = Results Pending

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 19E

DATA FIELD: Lead Screening **MC-19** R **DDE** R

Definition: The results of the lead screening examination.

Instructions: Print or type the results of the laboratory results.

Field Characteristics:

Values:
1 = Normal
2 = Abnormal - Treatment not required
3 = Abnormal - Treatment by Screening Provider
4 = Abnormal - Referral Other Provider
5 = Not Done
6 = Results Pending

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 20

DATA FIELD: IMMUNIZATION STATUS **MC-19** R **DDE** R

Definition: The status of immunizations.

Instructions: Indicate the status for each immunization.

Field Characteristics:

Values:
1 = Child is too young for the shot
2 = Complete for age at the end of visit
3 = Given but still incomplete for age
4 = Not given and still incomplete for age

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 20A

DATA FIELD: DPT or DT or Td **MC-19** R **DDE** R

Definition: The status of the DPT or DT or Td immunization.

Instructions: Indicate the status for each immunization.

Field Characteristics:

Values:
1 = Child is too young for the shot
2 = Complete for age at the end of visit
3 = Given but still incomplete for age
4 = Not given and still incomplete for age

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 20B

DATA FIELD: Oral Polio or IPV **MC-19** R **DDE** R

Definition: The status of the oral polio or IPV immunization.

Instructions: Indicate the status for each immunization.

Field Characteristics:

Values:
1 = Child is too young for the shot
2 = Complete for age at the end of visit
3 = Given but still incomplete for age
4 = Not given and still incomplete for age

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 20C

DATA FIELD: MMR **MC-19** R **DDE** R

Definition: The status of the MMR immunization.

Instructions: Indicate the status for each immunization.

Field Characteristics:

Values:
1 = Child is too young for the shot
2 = Complete for age at the end of visit
3 = Given but still incomplete for age
4 = Not given and still incomplete for age

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 20D

DATA FIELD: haem.b **MC-19** R **DDE** R

Definition: The status of the haem.b immunization.

Instructions: Indicate the status for each immunization.

Field Characteristics:

Values:
1 = Child is too young for the shot
2 = Complete for age at the end of visit
3 = Given but still incomplete for age
4 = Not given and still incomplete for age

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 21

DATA FIELD: Anticipatory Guidance/Health Education Given? **MC-19** OR **DDE** OR

Definition: This indicates if guidance or health education was given to the patient.

Instructions: Check appropriate box.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 22

DATA FIELD: Child Will Be Under My Continued Care? **MC-19** OR **DDE** OR

Definition: This indicates if the child will continue to receive services.

Instructions: Check appropriate box.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 23

DATA FIELD: Is Child Receiving WIC? **MC-19** OR **DDE** OR

Definition: This indicates if the child is enrolled in the Women/Infant/Children Program.

Instructions: Check appropriate box to indicate the child's status in the Women/ Infant/Children program.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 24

DATA FIELD: Physician's or Suppliers Name, Address and Zip Code

MC-19	R	**DDE**	R

Definition: The name, address, provider number, and telephone number of the provider submitting bill.

Instructions: Print or type the provider's name, address, telephone number and seven-digit Medicaid Provider Number, if it's not already preprinted on the claim form.

Field Characteristics:

Values:

Notes: For DDE claims, this field will be populated with the Provider Number that was logged in with on the website.

EFFECTIVE: March 2010 **FORM LOCATOR** 25

DATA FIELD: Signature of Physician or Supplier **MC-19** R **DDE** R

Definition: The provider signature and bill date. The provider signature (or authorized signature) certifies that the information on the claim is correct.

Instructions: The provider (or Authorized person(s)) must sign and date the claim form.

Field Characteristics:

Values:

Notes: For DDE claims, type your name and today's date.

EFFECTIVE: March 2010 **FORM LOCATOR** 26

DATA FIELD: SHCF No. **MC-19** NR **DDE** NR

Definition: Shared Health Care Facility Number

Instructions: Leave blank.

Field Characteristics:

Values:

Notes:

EFFECTIVE: December 2011 **FORM LOCATOR** 27

DATA FIELD: GSHP Referral No. **MC-19** OR **DDE** OR

Definition: Patient responsibility amount

Instructions: Use only to report a "Patient Responsibility Amount" when submitting a claim for reimbursement of a copayment, co-insurance or deductible.

Field Characteristics:

Values:

Notes: Refer to Newsletter Vol. 21 No. 24.

7.0 CLAIMS PAYMENT

Gainwell Technologies processes claims daily and produces provider payments and associated Remittance Advice (RA), i.e. Provider's account statements, once a week. See section 9.0 for further details. In the past, Checks and RAs were mailed to the provider's "Pay To" address as reflected on the NJMMIS Provider Master File that is maintained by Gainwell Technologies. Effective January 2012 paper checks and paper Remittance Advices will no longer be mailed. There are special circumstances in which a Provider may receive a hardcopy check or Remittance Advice.

The provider is responsible for informing Gainwell Technologies of all pertinent updates, changes, etc. to his/her information **in writing** in a timely fashion using the provider's letterhead or an established form provided by Gainwell Technologies. Providers may download a confirmation-change of address form from the Gainwell Technologies website at www.njmmis.com. Pertinent information is **all** information originally submitted with the provider's enrollment application and documentation. The provider must include the following:

- Clear instructions identifying the requested update, change, etc.
- Provider's NJ Medicaid 7 digit ID #.
- Servicing Provider's NJ Medicaid 7 digit ID #, if applicable.
- Authorized signature.

Failure to notify Gainwell Technologies promptly of such updates, changes, etc. may result in payment delays.

Confirmation of any updates, changes, etc. will be mailed to the provider upon request.

If you have any questions, contact the Gainwell Technologies Provider Enrollment Unit at 609-588-6036.

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8.0 ELECTRONIC FUNDS TRANSFER (EFT) - AUTOMATIC DEPOSIT

As of January 2012, it is mandatory that providers choose the EFT method of payment. There are special circumstances in which a Provider may receive a hardcopy check or Remittance Advice. The EFT option provides the provider an electronic deposit into his/her designated bank account.

Advantages:

- No waiting in lines at the bank to deposit a check. The funds are automatically transferred into the provider's bank account.
- Provider continues to receive a separate weekly RA statement detailing the claims submitted and related payment information for each payment cycle. As of January 2012 this will only be accessible by njmmis.com website.
- Funds are available upon receipt by the bank, generally on Friday. No longer waiting for a check to clear.
- Provider's payment cannot be lost, stolen, or forged. Postal service is not required.
- EFT is free. Funds are deposited directly into the provider's bank account of choice.

The EFT program is available to all providers enrolled in the Medicaid Program regardless of the claim volume. Providers may access their RAs on Monday via njmmis.com.

How to Enroll in the EFT program

1. Provider must complete an "Authorization Agreement for Automatic Payment/Deposits" form. See **Appendix E** for an instructional sample. The form can be obtained three (3) ways:
    - Copy this form from these billing instructions
    - Visit the Gainwell Technologies website at www.njmmis.com to download the form
    - Contact the Gainwell Technologies Provider Enrollment Unit at 609-588-6036

2. After completing the “Authorization Agreement” form, attach a blank, voided check which displays the provider's account # and bank’s transit/ABA #. This blank, voided check must accompany the completed form for processing.

    - The “Authorization Agreement” form must be signed by the provider or an authorized official (i.e. business manager, owner or facility administrator). If the account is a joint account, all parties must sign the form. If the signature can not be verified, the form will be returned to the provider.

3. The “Authorization Agreement” form and a blank, voided check should be mailed to:

Gainwell Technologies
Attention: Enrollment Unit
P.O. Box 4804
Trenton, NJ 08650-4804

When the “Authorization Agreement” form with a blank, voided check is received, Gainwell Technologies will initialize a test transaction. The zero (0) dollar transaction is sent to the provider’s bank to validate that the EFT is working properly and that the provider's account # and bank’s transit/ABA # are correct.

The bank requires a minimum of ten (10) working days to respond to a test transaction and to notify Gainwell Technologies of any detected problems. If no problems exist, Gainwell Technologies will begin processing/depositing EFT payments to the provider’s bank account.

The provider should allow four (4) weeks from the time of the EFT request to when the EFT payments begin. The four (4) week timeframe includes the mailing time requested for the EFT request and the processing times.

Once EFT option has been selected and funds are being transmitted electronically, any change to the EFT information (e.g., change of account #, ownership or authorized official) requires a new “Authorization Agreement” form be completed by provider. The provider should allow four (4) weeks for Gainwell Technologies to complete the change request. Under normal situations, a provider’s request to withdraw from EFT will be processed within ten (10) working days; however, a replacement must be submitted.

A history of frequent changes to the provider’s EFT information may result in the provider being withdrawn from this payment option.

9.0 REMITTANCE ADVICE (RA)

The purpose of this section is to familiarize the provider with the design and content of the RA. RAs reflect current claims status, financial data, and other health insurance information. RA statements are generated during the weekly payment cycle to each provider having claims activity during that cycle. The various pages of the RA are tailored by provider type and are generated only when there is applicable provider activity to be reported. A clear understanding of the data reported on the RA is necessary for providers to reconcile their Medicaid claims submissions. Gainwell Technologies will no longer send paper RAs as of January 2012. It must be accessed via njmmis.com Secured Options to view. If an older RA is needed, a request for a Judge Run must be submitted.

All claims processed through Gainwell Technologies NJMMIS falls into one of these three (3) statuses:

1. Paid
2. Suspended
3. Denied

Information pertaining to a provider's right to inquire into the status of Medicaid claims submitted to Gainwell Technologies for payment may be found in the Administrative Manual, Chapter 1 N.J.A.C. 10:49.

9.1 Approved Original Claims (Paid Claims)

A paid claim is a request for payment that has been adjudicated through Gainwell Technologies to effect reimbursement to a Medicaid-enrolled provider for a Medicaid-covered service provided to a Medicaid beneficiary. The claim appears on the RA's Claims Status page(s), along with all other paid claims in this payment cycle.

9.2 Claims in Process (Suspended Claims)

A suspended claim is a request for payment that has been pended for review by Gainwell Technologies or DMAHS to assure proper adjudication through Gainwell Technologies. The review will result in a claim being paid or denied. In the event that additional information is required, a Claim Correction Form (CCF) requesting the additional information will be available on the njmmis.com website.

See below a few examples as to why claims can suspend:

- Errors made while preparing the claim.
- Errors must be corrected by the provider who submitted the claim;
- The claim requires Medical Review by Gainwell Technologies or DMAHS;
- Information is missing or incomplete on the claim form.

9.3 Denied Claim

A denied claim is a request for payment that has been adjudicated through to Gainwell Technologies, but reimbursement is denied due to NJ Medicaid Program claims reimbursement policy.

Examples of reasons for denial:

- The beneficiary was not eligible on the date of service;
- The provider was not enrolled on the date of service;
- Prior Authorization (PA) is required, but was not obtained;
- The service is not covered by the Program;
- The claim is a duplicate;
- Service dates are invalid; or
- Program limitations have been exceeded.

9.4 Internal Control Number (ICN)

A unique thirteen (13) ICN is assigned to each Medicaid claim received by Gainwell Technologies. The ICN is reflected on the RA and is used to track the status of claims. The first five (5)digits of the ICN are the actual year and Julian date that the claim was received. A claim form with more than one claim service detail line completed has an ICN assigned to each completed line. The last two digits of the ICN determine which claim service detail line is being referenced:

Example: 0925023456701 - refers to first claim line
0925023456702 - refers to second claim line
0925023456703 - refers to third claim line

Thus, each claim service detail line is treated as a separate claim in the NJMMIS database. The unique 13 digit ICNs as reflected on a provider's RA may be used to monitor the current status of any claim from receipt through final disposition.

9.5 Checking the Status of a Claim

For each claim processed in a payment cycle, the ICN, beneficiary name, date(s) of service, and other pertinent claim information are printed on the RA. When applicable, the RA will display edit codes representing denial and payment reduction reasons. Messages explaining all edit codes found on the RA will be found on the Edit Code page.

If a medical record or patient account number (consisting of alpha and/or numeric characters) are entered on the claim form by the provider, the number will appear on the line immediately following the beneficiary's Medicaid Eligibility Identification (MEI) case number.

9.6 RA Cover Page

Each RA will be preceded by a cover page, an example of which follows.

The RA cover page is formatted as follows:

1. Page Header: The RA page header.

2. Date: The RA date.

3. Special Messages: The RA cover page is used to transmit special messages, billing instructions, procedure, or NDC code updates, and other pertinent information to providers. When there are no updates, this is left blank.

AS OF: MM/DD/YY

FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX-4801
TRENTON, NJ, 08650-4801

PROVIDERS MAY REQUEST A FAIR HEARING, IN WRITING, ON ANY VALID COMPLAINT OR ISSUE ARISING OUT OF THE CLAIMS PAYMENT PROCESS WITHIN TWENTY (20) DAYS FROM THE DATE OF THE REMITTANCE ADVICE STATEMENT IN ACCORDANCE WITH N.J.A.C. 10:49-10.3(a). WRITTEN REQUESTS FOR FAIR HEARINGS MUST BE ADDRESSED TO:

GAINWELL TECHNOLOGIES
FAIR HEARING UNIT
PO BOX 4801
TRENTON, NEW JERSEY 08650-4801

WHEN ADJUSTING A CLAIM THAT HAS PREVIOUSLY BEEN ADJUSTED, THE INTERNAL CONTROL NUMBER (ICN) OF THE ADJUSTED CLAIM MUST BE USED, NOT THE ICN OF THE ORIGINAL CLAIM.

SPECIAL NOTICE - ELIGIBILITY PROCESSING

THIS SPACE IS RESERVED FOR SPECIAL MESSAGES AND MAY CHANGE WEEKLY.
REFER TO THIS PAGE FOR MESSAGES FROM THE FISCAL AGENT AND THE DIVISION.

PROVIDER'S NAME
STREET ADDRESS
CITY, STATE ZIP CODE

9.6.1 Debit Financial Transaction Advice

The page(s) of the RA will display any debit financial transactions against a provider's account during the weekly payment cycle. If none, this page will not be generated by Gainwell Technologies.

Any payout to the provider and certain internal accounting transactions may result in a debit transaction on the debit financial page.

Debit Financial Transaction pages are formatted as follows:

1. Pay-To: The "Pay-To" Medicaid provider name and address.

2. Page Header: The RA page header.

3. Date: The RA date.

4. Remittance No: The unique number assigned to RA.

5. Provider No: The seven (7)-digit Medicaid provider number.

6. Page: RA page number.

7. Unlabeled: A short narrative description of each transaction.

8. Date: The date of each debit transaction.

9. Unlabeled: Check information, if applicable.

10. Processed Amount: The dollar amount of each debit transaction.

11. Remaining Balance: Any remaining debit balance in the provider's account after a debit transaction is posted.

12. Control Number: The NJMMIS number assigned to the debit transaction for audit purposes.

PROVIDERS' NAME
STREET ADDRESS
CITY, STATE ZIP CODE

DEBIT FINANCIAL TRANSACTION ADVICE
NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801
TRENTON, NJ 08650-4801

DATE: MM/DD/YY
REMITTANCE NO: 999999999
PROVIDER NO: 9999999

PAGE: 1

	DATE		PROCESSED AMOUNT	REMAINING BALANCE	CONTROL NUMBER
CLAIM VOID – WRONG RECIPIENT	MM/DD/YY	MMIS CHECK NUM: 345678765	11,423.28	9,839.09	9999999999999
AUDIT PAYMENT	MM/DD/YY		7,047.47	0.00	9999999999999
CLAIM ADJUST-PROVIDER TPL	MM/DD/YY	PROV CHECK NUM: 003224651	2,243.34	6,729.94	9999999999999
CLAIM RECEIVABLE CORRECTION	MM/DD/YY		13,954.92	0.00	9999999999999
TOTALS	TRANSACTIONS:		34,669.01	16,568.13	

9.6.2 Credit Financial Transaction Advice

The page(s) of the RA will display any credit financial transactions against a provider's account during the weekly payment cycle. If none, this page will not be generated by Gainwell Technologies.

Any recoupment of funds or certain internal accounting transactions may result in a credit transaction on the credit financial page.

Credit Financial Transaction Advice is formatted as follows:

1. Pay-To: The "Pay-To" Medicaid provider name and address.

2. Page Header: The RA page header.

3. Date: The RA date.

4. Remittance No: The unique number assigned to RA.

5. Provider No: The seven (7)-digit Medicaid provider number.

6. Page: RA page number.

7. Unlabeled: A short narrative description of each transaction.

8. Date: The date of each credit transaction.

9. Unlabeled: Check information, if applicable.

10. Processed Amount: The dollar amount of each credit transaction.

11. Remaining Balance: Any remaining credit balance in the provider's account after a credit transaction is posted.

12. Control Number: The NJMMIS number assigned to the credit transaction for audit purposes.

PROVIDER'S NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

CREDIT FINANCIAL TRANSACTION ADVICE
NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801
TRENTON, NJ 08650-4801

DATE: MM/DD/YY
REMITTANCE NO: 999999999
PROVIDER NO: 9999999

PAGE: 1

				PROCESSED AMOUNT	REMAINING BALANCE	CONTROL NUMBER
AUDIT RECOUPMENT		DATE MM/DD/YY	NEW ACCOUNT: $20,000.00	15,550.00	4,450.00	9999999999999
CLAIM ADJUST-PROVIDER TPL		MM/DD/YY		2,600.00	0.00	9999999999999
TOTALS	TRANSACTIONS:			18150.00	4,450.00	

9.6.3 Physicians' Services RA Page(s)

The page(s) of the RA displays pertinent information for all claims processed by Gainwell Technologies for a provider during the current payment cycle and provides a status for each.

All information included in Items 7 through 18 will be displayed for all claims processed during the payment cycle. Claims will be categorized as follows:

- Approved Original Claims (Paid);
- Denied Claims;
- Voided Claims;
- Adjustments to Previously Paid Claims; and
- Claims in Process (Pended Claims).

The claim status page(s) is formatted as follows:

1. Pay-To: The "Pay-To" Medicaid provider name and address.

2. Page Header: The RA page header.

3. Date: The RA date.

4. Remittance No: The unique number assigned to RA.

5. Provider No: The seven (7)-digit Medicaid provider number.

6. Page: RA page number.

7. Recipient ID (Med Record No): The beneficiary's Medicaid Eligibility Identification (MEI) case number. If a medical record number is entered on the claim, the number will be printed on the RA page directly under the beneficiary's MEI case number, along with the servicing provider's Medicaid provider number.

8. Recipient Name: The beneficiary's last name is printed first, followed by the first initial of the first name.

9. Dates of Service: The date(s) the beneficiary(s) received services.

10. Units: The number of days or units of service paid, denied, or suspended, as appropriate.

11. Procedure/Mods: The procedure code and applicable modifier(s).

12. Description: A brief description of the procedure code/modifier(s).

13. Amount Billed: The dollar amount entered on the claim form for the service rendered.

14. Amount Allowed: The amount Medicaid allows for the service rendered.

15. Total Deduct: Amount deducted from the Medicaid tentative payment.

16. Amount Paid: The amount paid by Medicaid.

17. Control Number: The NJMMIS ICN used to track and report claims processed by the Gainwell Technologies.

18. Edit codes: Applicable claim edit codes printed immediately above the claim total lines in each category. For each edit code posted to a provider's claim during a payment cycle, a corresponding edit code explanation is found on the RA Edit Codes Page.

PROVIDER'S NAME
STREET ADDRESS
CITY, STATE ZIP CODE

PHYSICIAN SERVICES REMITTANCE ADVICE
NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801
TRENTON, NJ 08650-4801

DATE: MM/DD/YY
REMITTANCE NO: 999999999
PROVIDER NO: 9999999

RECIPIENT (MED RECORD NO)	RECIP NAME		DATES OF SERVICE FROM	THRU	UNITS	PROCEDURE/DESCRIPTION MODS		BILLED AMOUNT	AMOUNT ALLOWED	TOTAL DEDUCT	AMOUNT PAID	CONTROL NUMBER
APPROVED ORIGINAL CLAIMS												
111111111111	BROWN	J	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	40.00	13.30	.00	13.30	9999999999999
(5806)/PHYS			NO: 7777777									
APPROVED ORIGINAL CLAIM TOTALS							1 CLAIM	379.00	144.72	.00	144.72	
ADJUSTED CLAIMS												
111111111111	LUCIANO	E	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	20.00	11.20	.00	11.20	9999999999999
(0580047132004138)/PHYS			NO: 7777777									**ADJUSTMENT**
111111111111	LUCIANO	E	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	10.00	10.00	.00	10.00	9999999999999
(0580047132004138)/PHYS			NO: 7777777									ORIGINAL
ADJUSTED CLAIM TOTALS							1 CLAIM	1029.50	1029.50	.00	1029.50	
PREVIOUSLY PAID CLAIM TOTALS							1 CLAIM	493.00	493.00	.00	493.00	
VOIDED CLAIMS												
111111111111	IQBAL	B	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	20.00	11.20	.00	11.20	9999999999999
(0580053112004152)/PHYS			NO: 7777777									
VOIDED CLAIM TOTALS							1 CLAIM	.00	429.50	.00	429.50	
DENIED CLAIMS												
111111111111	CORDON	D	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	50.00	.00	.00	.00	9999999999999
(1234581)PHYS			NO: 7777777		ERROR CODES:		0301					
DENIED CLAIM TOTALS												
CLAIMS IN PROCESS												
111111111111	OWENS	P	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	40.00	.00	.00	.00	9999999999999
(7489)/PHYS			NO: 7777777		ERROR CODES:		0026 0464					
CLAIMS IN PROCESS TOTALS							1 CLAIM	127.00	.00	.00	.00	
CLAIMS IN PROCESS - CCF												
111111111111	SMITH	A	MM/DD/YY	MM/DD/YY	1	99999	SERVICES	40.00	.00	.00	.00	9999999999999
(4321)/PHYS			NO: 7777777									
CLAIMS IN PROCESS - CCF TOTALS							1 CLAIM	80.00	.00	.00	.00	

9.6.4 RA Edit Code Page

The page of the RA will list all claim edit codes that are applicable to a Medicaid provider's claims for the current payment cycle. An example of the RA Edit Codes page follows.

The RA Edit Codes page is formatted as follows:

1. Pay-To: The "Pay-To" Medicaid provider name and address.

2. Page Header: The RA page header.

3. Date: The RA date.

4. Remittance No: The unique number assigned to RA.

5. Provider No: The seven (7)-digit Medicaid provider number.

6. Page: The RA page number.

7. Edit Codes: The list of edit codes and the corresponding explanation.

CODE DESCRIPTION

0026 CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING

0301 RECIPIENT INELIG ON DATE OF SERVICE

0464 HIPAA CLAIM REQUIRES ATTACHMENT

0670 NO PAYMENT DUE – MEDICARE PAYMENT EXCEEDS MEDICAID ALLOWANCE

0979 RECIPIENT IS MEDICARE ELIGIBLE

***SEE WEBSITE FOR FURTHER DETAILS AND/OR EXPLANATIONS**

9.6.5 Remittance Summary Page(s)

The page(s) of the RA will summarize a provider's claims activity for the current payment cycle.

1. Pay-To: The "Pay-To" Medicaid provider name and address.

2. Page Header: The RA page header.

3. Date: The RA date.

4. Remittance No: The unique number assigned to RA.

5. Provider No: The seven (7)-digit Medicaid provider number.

6. Page: RA page number.

7. Summary Information: Summary information pertaining to a provider's claims activity during the current payment cycle is displayed, including total claim volumes, by category, and associated financial totals. Financial data will include month-to-date and year-to-date amounts paid to a provider.

PROVIDER'S NAME
STREET ADDRESS
CITY, STATE ZIP CODE

REMITTANCE SUMMARY
NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801
TRENTON, NJ 08650-4801

DATE: MM/DD/YY
REMITTANCE NO: 999999999
PROVIDER NO: 999999999

	CURRENT NUMBER	TRANSACTION AMOUNT
APPROVED ORIGINAL CLAIMS	14	144.72
ADJUSTMENT CLAIMS	1	10.00
PREVIOUSLY PAID CLAIMS	1	8.00
VOIDED CLAIMS		.00
NET CURRENT CLAIM TRANSACTIONS	15	146.72
NET CURRENT FINANCIAL TRANSACTIONS		.00
TOTAL PAYMENT THIS REMITTANCE		146.72
YEAR-TO-DATE AMOUNT PAID		738.91
DENIED CLAIMS	3	90.00
CLAIMS IN PROCESS	12	207.00

LAST REMITTANCE NO: 999999999 DATED: MM/DD/YY

Definition of:

Net Current Claim Transaction

The sum of approved original claims plus adjustments minus any previously paid claims and voids

Net Current Financial Transaction

The sum of any financial recoupments and payouts in this cycle

9.6.6 Insurer Data Summary Page

The page(s) of the RA displays data pertaining to a Medicaid beneficiary's other health insurance coverage, if applicable. This information will be generated by the NJMMIS only for claims which are denied because other health insurance was available on the date(s) of service.

1. Pay-To: The "Pay-To" Medicaid provider name and address.

2. Page Header: The RA page header.

3. Date: The RA date.

4. Provider No: The seven (7)-digit Medicaid provider number.

5. Page: RA page number.

6. Recip Name: This displays the beneficiary specific information relating to each claim being reported, including the beneficiary name, beneficiary MEI case number, relationship to the insured person, and the ICN used to track and report claims processed by Gainwell Technologies.

7. Carrier ID: This information identifies other health insurance carriers, including the appropriate carrier code, carrier name and address.

TO: PROVIDER'S NAME
STREET ADDRESS
CITY, STATE ZIP CODE

NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801
INSURER DATA SUMMARY

DATE: MM/DD/YY
PROVIDER NO: 9999999
PAGE: 1

BENEFICIARY NAME: DOE, JOHN
BENEFICIARY NO: 999999999999
REL: BENEFICIARY ICN: 9999999999999

CARRIER ID: 042
CARRIER NAME: GOODLIFE INSURANCE, INC
CARRIER ADDRESS: 2344 FOREVER BOULEVARD
CARRIER ADDRESS: PO BOX 26373
CITY ST ZIP: ANYTOWN IN 99999

INSURED: DOE, JOHN
POLICY NO: XXXXXXXXXXXXX
POLICY HOLDER NAME: JOHN DOE

BENEFICIARY NAME: DOE, JANE
BENEFICIARY NO: 999999999999
REL: SPOUSE ICN: 9999999999999

CARRIER ID: 105
CARRIER NAME: NIRVANA ASSURANCE, LMTD
CARRIER ADDRESS: AMBROSIA BLDG, SUITE 107C
CARRIER ADDRESS: 2874 VALHALLA DRIVE
CITY ST ZIP: SOMEPLACE MO 99999

INSURED: DOE, JOHN
POLICY NO: 658M7J9S94319
POLICY HOLDER NAME: JOHN DOE

9.7 Claim Correction Form (CCF)

CCFs are generated by Gainwell Technologies for claims that have been suspended due to missing or incorrect claim data. CCFs are preprinted with claim form data field descriptions. Within each data field description, corresponding information taken from the original claim is displayed (changes are to be made in the field that generated the error). Each CCF displays an edit code with the corresponding reason(s) for which the original claim suspended. All necessary changes/corrections are to be completed in the applicable claim data field(s).

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

CCFs must be completed within the expiration date of the date it was generated or a new claim must be submitted.

Completed the CCF - TIPS

- Return the pages with corrections ONLY
- Use Blue or Black ink ONLY
- Use Provider Numbers, not Names
- Corrections must be Written on the Dotted Line directly below the field in error
- Do Not Write Corrections in the box where the error message appears
- Do Not Submit Attachments with the CCF
- Put an Asterisk (*) or a Wavy Line (~) on the dotted line below the field to delete the item
- The CCF will no longer come with the Remittance Advice (RA). It may be completed by accessing the Secured Options on www.njmmis.com - refer to Newsletter Vol. 13 No. 22, provider has 53 days to complete.

AAA CLAIM CORRECTION FORM

1500

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
NEW JERSEY HEALTH SERVICES PROGRAM

REMIT DATE: **MM/DD/YY**

CONTROL NO.	**99999-9999-99**	LINE(S):	**99**	THRU:	**99**	DETAIL LINE NO:	**99**

99 99 99 99999 9999 99 99 99 99

RECIPIENT NAME / DATE OF BIRTH ON FILE: **DOE JANE MM/DD/YYYY**

ERROR CODES

FOR A DESCRIPTION OF THE ERROR CODES SEE REVERSE SIDE OF THIS PAGE

BILLING PROVIDER A1	MULT ADDR A2	NAME ON CLAIM LAST A3	NAME ON CLAIM FIRST A4	BIRTH DATE A5	MEDICAID ID NUMBER A6	OTHER INS A7	CARRIER CODES A8	A9	A10
9999999	**01**	**DOE**	**J**	**MM/DD/YY**	**9999999999**	**N**			

INDICATORS EMPLOY B1	INDICATORS ACCID B2	REFERRING PROVIDER B3	INDICATORS LAB B4	INDICATORS EPSDT B5	PRIOR AUTHORIZATION NUMBER B6	SHCF NUMBER B7	GSHP AUTHORIZATION NUMBER B8
N	**N**	**1234567**	**N**	**N**	**9999999999**	**0000000**	

VISION EXAM DATE PREV C1	VISION EXAM DATE CURR C2	(OPT) DISPENSED DATE C3	(OPT) PRESCRIBING PROVIDER C4	TOOTH CODE C5	TOOTH SURFACE C6	FAMILY PLAN C7	PATIENT ACCOUNT NUMBER C8
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N**	**999999999**

DATE OF SERVICE FROM D1	DATE OF SERVICE THRU D2	POS/ ORIG D3	TOS/ DEST D4	PROCEDURE CODE D5	PROCEDURE MOD D6	PROCEDURE MOD D7	DIAGNOSIS CODE D8	DIAGNOSIS CODE D9	DAYS UNIT D10	LINE CHARGE D11	SERVICING PROVIDER D12
MM/DD/YY	**MM/DD/YY**	**53**	**01**	**99213**			**304**		**1**	**25.00**	**9999999**

TOTAL CHARGE E1	PAID BY OTHER INSURANCE E2	DATE BILLED E3	MEDICARE PROVIDER NUMBER E4	MEDICARE CLAIM NUMBER E5	MEDICARE ID (MBI) E6
25.00	**0.00**	**MM/DD/YY**			

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10.0 ADJUSTMENTS

An “Adjustment Request” form (FD-999) is utilized when requesting an adjustment to a claim that has been processed. There are three (3) ways to obtain the form:

- Photocopy a blank FD-999 form.
- Visit the Gainwell Technologies website at www.njmmis.com to download the form
- Contact the Gainwell Technologies Provider Services Call Center at 800-776-6334

An FD-999 form is completed when a claim is paid with incorrect data or in error. Each claim service detail line is identified with its own unique thirteen (13) digit ICN #. The FD-999 form is the appropriate method to correct a claim service detail line. One (1) “Adjustment Request” form per claim service detail line is required. An instructional sample is included in this section. See below a few examples that may cause under or overpayment:

- Payments are received from a private insurance company after the claim was paid
- Provider billing errors
- Gainwell Technologies processing errors.

10.1 Overpayment

If a provider receives an overpayment the provider must complete an FD-999 form with an attached copy of the claim, and a copy of the RA that accompanied the check for payment of that claim. The FD-999 form along with the attachments should be mailed to:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

A properly completed FD-999 form received by Gainwell Technologies will be processed and the adjustment will appear on a future RA; the overpayment amount will be deducted from the current payment. Providers **should not** submit a reimbursement check for the overpayment amount.

If the claim was submitted electronically, there is no claim form to attach to the FD-999. Print or Type on the upper right hand corner of the FD-999 “**EDI**”.

10.2 Underpayment

If a provider receives an underpayment the provider must complete an FD-999 form with an attached copy of the claim, and a copy of the RA that accompanied the claim. It should be mailed to:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

The request will be processed and appear on a future RA with the underpayment amount credited to the current payment.

If the claim was submitted electronically, there is no claim form to attach to the FD-999. Print or Type on the upper right hand corner of the FD-999 "**EDI**."

10.3 Void

If a claim is paid in error, then the provider must complete an FD-999 form and attach a copy of the RA that accompanied the payment of the claim in question. It should be mailed to:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

Once received by Gainwell Technologies, the FD-999 form will be processed and appear on a future RA with the voided amount deducted from the current payment. Providers **should not** submit a reimbursement check for the voided amount. If a check is included, the void will be delayed because special handling will be needed to mail the check back to the provider.

On the FD-999 form, print or type "Void" in the description section. Resubmit the claim after the void appears on the RA.

10.4 Adjustments by Medicare and Other Insurance Carriers

If an Adjustment is made by another payer (i.e. Medicare or other health insurance carriers) that results in an overpayment or underpayment to a provider, and thereby affects the Medicaid payment, then the provider must complete an FD-999 form. This is in order to correct the initial Medicaid/NJ FamilyCare payment. The provider must include, with the FD-999, a completed claim, a copy of the original EOB, the adjustment notice, and a copy of the applicable RA. It should be mailed to:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

If the claim was submitted electronically, there is no claim form to attach to the FD-999. Print or Type on the upper right hand corner "**EDI**'.

Tips on Completing the FD-999

- Be specific about the change. Indicate what should be changed in order to receive a correct payment.

- One (1) item may be adjusted per request. Supporting documentation must be attached.

- Adjustment descriptions should include what correction the provider is requesting to the original paid claim amount. Be clear and concise.

- If the information was previously adjusted, the ICN # of the adjusted claim should be used (not the ICN# from the original claim). Describe what was incorrect and the changes that are being requested. The explanation should not be: "Medicaid owes us $52.00;" this does not address the necessary change. Assumptions cannot be made by Gainwell Technologies staff about what is being disputed.

- Denied claims cannot be adjusted. A claim denied must be resubmitted for processing. Proof of timely filing must be attached if the claim is outside the timely filing guidelines.

- Adjustments and Voids can now be completed through the NJMMIS website.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

MMIS CLAIM ADJUSTMENT REQUEST FORM

ATTACH: Copy of original claims with corrections
Required claim attachments
Copy of Remittance Advice

1. Provider Number: 9 9 9 9 9 9 9

2. Provider Name:

John Doe Counseling

3. Provider Address:

1 Any St

Anytown, NJ **01234**
City, State Zip Code

4. Reason (Circle One)

04	Claim Correction*
05	Void - Wrong Provider
06	Void - Wrong Recipient
07	Void - Service Not Provided
37	Insurance Recovery
61	LTC Patient Liability Change
62	LTC Leave of Absence Correction
	STATE OFFICE USE ONLY A☐ V☐

*Explain Below in Item 5

5. Description of the Problem: **Change units in 17D to 2.**

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

6. Control Number (ICN): 1 0 0 5 9 0 1 6 5 6 4 0 1

7. Recipient Name: **DALTON** **STEVEN**
Last First MI

8. Recipient HSP Number: 9 9 9 9 9 9 9 9 9 9 1 0

9. Remittance Advice Date: 0 5 3 1 1 0
M M D D Y Y

10. Provider Signature: _____ Date: _____

Send to: Gainwell Technologies, P.O. Box 4802, Trenton, NJ 08650

FISCAL AGENT USE ONLY

Date: _____ Reviewer: _____ Form Locator: ☐☐☐

FD 999 (01/21)

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

MMIS CLAIM ADJUSTMENT REQUEST FORM

ATTACH: Copy of original claims with corrections
Required claim attachments
Copy of Remittance Advice

1. Provider Number: 9 9 9 9 9 9 9

2. Provider Name:

John Doe Counseling

3. Provider Address:

1 Any St

Anytown, NJ **01234**
City, State Zip Code

4. Reason (Circle One)

04	Claim Correction*
05	Void - Wrong Provider
06	Void - Wrong Recipient
07	Void - Service Not Provided
37	Insurance Recovery
61	LTC Patient Liability Change
62	LTC Leave of Absence Correction
	STATE OFFICE USE ONLY A☐ V☐

*Explain Below in Item 5

5. Description of the Problem: **Void.**

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

6. Control Number (ICN): 1 0 0 4 0 0 1 3 8 4 7 0 2

7. Recipient Name: **LUTZ** **TIM**
Last First MI

8. Recipient HSP Number: 9 9 9 9 9 9 9 9 9 9 9 1

9. Remittance Advice Date: 0 5 3 1 1 0
M M D D Y Y

10. Provider Signature: *Original Signature* Date: **04/01/10**

Send to: Gainwell Technologies, P.O. Box 4802, Trenton, NJ 08650

FISCAL AGENT USE ONLY

Date: _____ Reviewer: _____ Form Locator: ☐☐☐

FD 999 (01/21)

EFFECTIVE: March 2010 **FORM LOCATOR** 1

DATA FIELD: Provider Number R

Definition: The seven (7)-digit provider number

Instruction: Print or type the seven (7)-digit Medicaid Provider ID # that was on the original claim.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 2

DATA FIELD: Provider Name

R

Definition: The provider name of original claim.

Instruction: Print or type the provider name that was on the original claim.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 3

DATA FIELD: Provider Address R

Definition: The physician's/supplier's Billing Address, Zip Code.

Instruction: Print or type the provider's address, telephone number, and Provider Medicaid ID #.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 4

DATA FIELD: Reason

R

Definition:

Instruction: Circle the appropriate numeric reason code for the adjustment request.

Field Characteristics:

Values:

Notes: When requesting a void that doesn't fit 05, 06 or 07, circle 07.

EFFECTIVE: March 2010 **FORM LOCATOR** 5

DATA FIELD: Description of the Problem | OR |

Definition:

Instruction: State changes (if any) to the original claim form that are being requested. Changes to be made must be clearly described.

When adjusting the claim, an FD-999 must be completed for each line to be adjusted.

Field Characteristics:

Values:

Notes: When requesting a void, this item is not required.

EFFECTIVE: March 2010 **FORM LOCATOR** 6

DATA FIELD: Control Number (ICN) R

Definition:

Instruction: Print or type the thirteen (13) digit Internal Control Number (ICN) of the claim **EXACTLY** as it is printed on the RA. Only one (1) ICN may be requested for adjustment on each FD-999.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 7

DATA FIELD: Recipient Name

R

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

Instruction: Print or type the beneficiary's name **EXACTLY** as it is printed on the Health Benefits Identification Card. Last name must be entered first.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 8

DATA FIELD: Recipient HSP (Medicaid) Number

R

Definition: The twelve (12)-digit number that designates the beneficiary's identification number.

Instruction: Print or type the beneficiary's Medicaid Eligibility Identification number and person number.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 9

DATA FIELD: Remittance Advice Date

R

Definition:

Instruction: Print or type the date that is printed on the top right corner of the RA.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 10

DATA FIELD: Last Payer

R

Definition:

Instruction: Indicate the Gainwell Technologies responsibility for the most recent processing of the claim.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 11

DATA FIELD: Provider Signature

R

Definition:

Instruction: Sign using an original signature of the provider and the date of the signature.

Field Characteristics:

Values:

Notes:

Mail all Adjustment Requests to the following address:

Gainwell Technologies
P.O. Box 4802
Trenton, NJ 08650-4802

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11.0 ORDERING FORMS

Specific forms must be ordered by using the "NJMMIS Form Request" form. There are two (2) ways to obtain this request form:

- Visit the Gainwell Technologies website at www.njmmis.com to download the form, or
- Contact the Gainwell Technologies Provider Services Call Center at 800-776-6334. (This form will be mailed directly to the provider.)

To obtain the specific forms listed below, the provider must complete the "NJMMIS Form Request" form and mail it to:

Gainwell Technologies
Attention: Forms Distribution
P.O. Box 4804
Trenton, NJ 08650-4804

Notes: Providers should order only a three (3) month supply at a time. Allow for a three (3) week delivery turn-around-time.

Gainwell Technologies is responsible for the distribution of the following forms:

NUMBER	FORM TITLE
MC-6	Prescription Claim
MC-9	Request for Authorization and Payment – Optical Appliances
MC-12	Transportation Claim
MC-19	Report and Claim Form for EPSDT/HealthStart Screening and Related Procedure
Prior Authorization Forms	
MC-10(A)	Dental Prior Authorization
FD-06	Prior Authorization for Rehabilitative Services
FD-07	Request for Authorization for Mental Health and/or Mental Health Rehabilitative 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-365	Prior Authorization Request

NUMBER	FORM TITLE
FD-411	Prior Authorization Request for Adult Day Health Services
FD-413	New Jersey Department of Health and Senior Services Pediatric Medical Day Care Services Prior Authorization
Attachment Forms	
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
HLD (NJ-Mod)	New Jersey Orthodontic Evaluation
Miscellaneous Forms	
FD-197	Patient Certification Form
	Medicaid Second Opinion Newsletters (Vol. 10 No. 83 for Hospitals), (Vol. 10 No. 85 for All Other Provider Types)
FD-999	Adjustment Request Form-NJMMIS Medicaid
FD-998	Medicaid Claim Inquiry/Response Form

Appendix A
Medicaid Claims Inquiry/Response (I/R) Form

The Inquiry/Response (I/R) form is a multi-part form that has been designed to ease the processing of written inquiries to the Gainwell Technologies Provider Communications staff. A total of three inquiries can be submitted on each I/R form. To request a supply of these forms, refer to **Section 11**.

After entering all necessary data on the I/R form, tear off the last copy and retain for office records. Send the remaining two (2) copies, along with a legible copy of the claims in question, and (if applicable) a copy of the RA to Gainwell Technologies. The Correspondence Specialist will research the inquiry and will enter respond to your inquiry.

How to use the I/R Form

- The I/R form should be used for written inquiries about a claim.

- Do not use to resubmit a denied claim. Using this form to resubmit a denied claim delays the processing of that claim. Previously denied claims should be submitted to the correct processing address after the condition that caused the denial has been corrected.

MEDICAID CLAIM INQUIRY/RESPONSE FORM

INSTRUCTIONS:

Attach a copy of your claim form(s) and any applicable documentation, e.g. a copy of the claim, reports, Remittance Statements. Fill in information at top of form; write or type your question in the INQUIRY area. Print your name and date the form. Send Parts 1 and 2. Retain Part 3 for your records. Part 1 will be returned with reply.

PROVIDER'S NAME & ADDRESS

Company Inc.

999 Oak Leaf Lane

Anytown, NJ 08111

MEDICAID PROVIDER NUMBER 9 9 9 9 9 9 9

PROVIDER'S GROUP # 6 6 6 6 6 6 6

PROVIDER'S TELEPHONE # 6 0 9 / 5 5 5 - 5 5 5 5

CLAIM INFORMATION

RECIPIENT'S NAME	HSP (MEDICAID) CASE / REASON NO	DATE OF SERVICE	REMITTANCE DATE	INTERNAL CONTROL NUMBER
1. Joe Doe	123033219001	02/10/20	02/27/20	200135001123401
2. Jane Doe	321121230901	02/01/20		
3. John Doe	202013421520	01/30/20		200133611231402

INQUIRY

Claim was resubmitted on 05-02-20. Have not received claim payment.

REQUESTER'S NAME Janet Doe **DATE** 8/26/20

PLEASE PRINT

RESPONSE

A review indicates payment was made on 04-29-20. Please check your Remittance Advice.

PROVIDER INQUIRY
GAINWELL TECHNOLOGIES
PO BOX 4801
TRENTON, NJ 08650

FD-998 (1/21)

SIGNATURE LD **DATE** 9/3/20

EFFECTIVE: March 2010 **FORM LOCATOR** 1

DATA FIELD: PROVIDER'S NAME AND ADDRESS | R |

Definition: The name and address of provider.

Instruction: Print or type the provider's complete name and mailing address.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 2

DATA FIELD: MEDICAID PROVIDER NUMBER | R |

Definition:

Instruction: Print or type the seven (7)-digit Medicaid provider ID #.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 3

DATA FIELD: PROVIDER'S GROUP NUMBER | OR |

Definition:

Instruction: Print or type the seven (7)-digit Medicaid provider group ID #, if applicable.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 4

DATA FIELD: PROVIDER'S TELEPHONE # R

Definition:

Instruction: Print or Type the telephone number of the person completing the Inquiry/Response form.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 5

DATA FIELD: RECIPIENT'S NAME | R |

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

Instruction: Print or type the beneficiary's name.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 6

DATA FIELD: HSP (MEDICAID) CASE / PERSON NO. R

Definition: The number that designates the beneficiary's NJ Medicaid Identification Number.

Instruction: Print or type the beneficiary's Medicaid Eligibility Identification and Person Number.

- For PAAD beneficiaries, copy the PAAD identification number **EXACTLY** as it is printed on the PAAD Eligibility Card.
- For ADDP, CBHS, GA or CF, copy the number as on the card or letter issued to the beneficiary of these programs.
- For newborns, use the eligibility Number and Person Number of mother for up to 60 days from the date of birth of newborn (through last day of the month in which the 60th day occurs).

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 7

DATA FIELD: DATE OF SERVICE

R

Definition: The start and end date.

Instruction: Print or type the "from" and "to" dates of service to which the claim applies using the month, day, and year (MMDDYY) format.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 8

DATA FIELD: REMITTANCE DATE | OR

Definition: The RA date.

Instruction: Print or type the RA date, if the claim in question was listed on a RA.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 9

DATA FIELD: INTERNAL CONTROL NUMBER | OR |

Definition:

Instruction: Print or type the 13-digit ICN # for the claim in question, if known.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 10

DATA FIELD: INQUIRY R

Definition:

Instruction: Print or type a description of the problem or inquiry.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 11

DATA FIELD: REQUESTOR'S NAME

R

Definition: The person completing the I/R form.

Instruction: Print or type the requestor's name.

Field Characteristics:

Values:

Notes:

EFFECTIVE: March 2010 **FORM LOCATOR** 12

DATA FIELD: DATE

R

Definition: The date of request.

Instruction: Print or type the date of the request.

Field Characteristics:

Values:

Notes:

Appendix B
Return To Provider Letter

This letter will accompany claims that have been rejected during the Gainwell Technologies screening process. After making the requested corrections, the provider should resubmit the claim to the appropriate P.O. Box # as listed below.

MAIL TYPE	P.O. BOX #
Claim Correction Form (CCF)	4802
1500 (formerly CMS-1500)	4802
Computer Operations (EDI)	4814
Dental	4802
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	4802
Fair Hearing	4801
Good Faith	4801
HBID	4803
Long Term Care (LTC) - Turn Around Document (TAD)	4805
Medicare/Medicaid Crossovers	4802
Pharmacy	4802
Provider Correspondence	4801
Provider Enrollment	4804
Transportation	4802
UB-92/UB-04 Hospital Inpatient/Outpatient & Home Health Agency Services	4802
Vision	4802
Written Inquiries	4801

RETURN TO PROVIDER FORM

JULIAN DATE _____

REVIEWER **DP-** _____ DATE _____

The enclosed form(s) is (are) being returned to you by Gainwell Technologies, the New Jersey Medicaid Fiscal Agent, for the reason(s) indicated below. Please refer to your Billing Supplement or www.njmmis.com on the internet for detailed billing instructions.

☐ **Missing** / **Invalid** PAYOR CODE. Medicaid PAYOR CODE is 012, and is required in BLOCK 50. (UB-04)

☐ **Missing** / **Invalid** TYPE OF BILL IN BLOCK 4. (UB-04)

☐ Continuation claims are no longer processed (non UB-04 claims). Please total each page

☐ CMS-1500 (formerly HCFA-1500) claim CANNOT exceed 6 lines

☐ UB-04 claim lines CANNOT exceed 45

☐ Patient Liability/Prior Pay Do Not Match EOB

☐ Invalid Form. Resubmit on CMS-1500 (rev 02-12)

☐ Invalid Form _____. Resubmit on claim form _____

☐ Illegible/old form(s). Resubmit on appropriate form

☐ Missing claim form. (Received attachments only)

☐ Each claim must have its own attachments

☐ No negative billed charges accepted

☐ No charges on claim

☐ Dental forms MUST have DATES OF SERVICE

☐ **Missing** / **Invalid** 7 digit Billing Provider Number. Valid number MUST be in Block_____

- ☐ 7 digit Billing Provider Number MUST be in BLOCK 33B (CMS-1500 REV 02-12).

☐ **Missing** / **Invalid** Original Provider Signature. NO Stamped, Computer Generated Signatures or initials accepted.

- ☐ Invalid Provider Signature (must be original provider signature or signature of authorized designee). The enclosed claims are being returned due to same handwriting for each physician/supplier or different handwriting for same physician/provider (RA Message Number 425, 8/01/01)

☐ Recipient Signature field MUST be recipient signature or state "signature on file".

CLAIM/EOB or EOMB:

- ☐ **NAMES / DATES** on the claim form DO NOT match the **EOB/EOMB**.
- ☐ Each claim form MUST have its own **EOB/EOMB** attachment.
- ☐ Medicaid Charges/Total Charges MUST match Medicare EOMB billed charges.(CMS-1500)
- ☐ Other: _____
- ☐ Other: **MEDICAID QUALIFIER IS MISSING OR MEDICAID QUALIFIER _____ IS INVALID**

NOTE: THIS DOCUMENT CANNOT BE USED AS PROOF OF TIMELY FILING.
Please resubmit revised/corrected forms to Medicaid Fiscal Agent using the appropriate PO Box number.

Rev. 01/21

Appendix C

Insurance Carrier Codes - Numeric

CARRIER CODE	PAYOR CODE	INSURER NAME
001	280	BC/BS OF NEW JERSEY
002	303	BC/BS OF NEW YORK (NEW YORK CITY)
003	362	BC/BS OF PHILADELPHIA
004	029	ALL OTHER BC/BS (DO NOT USE)
005	091	ALL UNION LOCAL INSURANCE
006	105	AETNA US HEALTHCARE
007	186	ALLSTATE
008	107	AARP CLAIMS
009	199	AMERICAN GENERAL INSURANCE
010	199	AMERICAN NATIONAL
011	199	PRINCIPLE FINANCIAL GROUP
012	199	BENEFIT TRUST LIFE
013	199	PEOPLES BENEFIT INSURANCE
014	014	HEALTHNET TRICARE NORTHERN REGION
015	199	UNITY MUTUAL LIFE
017	199	CAN
018	199	COLONIAL LIFE AND ACCIDENT
019	199	COLUMBIA LIFE INSURANCE
020	115	CIGNA (CONNECTICUT GENERAL)
022	120	CONTINENTAL ASSURANCE
023	199	UNION FIDELITY LIFE INS.
024	199	EMPLOYER'S HEALTH INSURANCE
025	125	AXA EQUITABLE
026	125	EQUITABLE
027	022	FEDERAL BLUE CROSS
028	199	FIREMAN'S FUND
029	199	GARDEN STATE HOSPITALIZATION NJ
030	199	GHI CLAIMS DEPARTMENT
031	199	GREAT WEST LIFE & ANNUITY
032	131	GUARDIAN LIFE/HEALTHNET
033	046	HIP HEALTH PLAN OF NEW JERSEY
034	074	CIGNA HEALTHCARE HMO
035	199	INDEPENDENT LIFE
036	135	INTERCONTINENTAL
037	194	INTER COUNTY HEALTH PLAN
038	142	JOHN HANCOCK L.I.C. NOW UNICARE
039	199	LIBERTY MUTUAL
040	199	LIFE INSURANCE CORP., OA

CARRIER CODE	PAYOR CODE	INSURER NAME
041	199	VIRGINIA HEALTH NETWORK
042	198	MAIL HANDLERS BENEFIT PLAN
043	199	CAPITAL ENTERPRISES, INC.
044	145	MASSACHUSETTS MUTUAL
045	151	METROPOLITAN
046	096	QUALCARE PROVIDER
047	199	COLONIAL PENN
048	199	MUTUAL BENEFIT
049	187	MUTUAL OF NEW YORK
050	155	MUTUAL OF OMAHA
051	188	NATIONAL ASSOCIATION OF LETTER CARRIERS
052	199	FEDERAL EXPRESS
053	199	NATIONAL MARITIME UNION
054	195	APWU/AMERICAN POSTAL WORKERS UNION
057	161	NEW YORK LIFE/NYLCARE
058	199	NEW YORK SHIPPING ASSOCIATION
059	199	LOCAL 798 WELFARE FUND
060	199	NORTHWESTERN NATION LIFE
061	199	OCCIDENTAL LIFE INSURANCE
062	199	PACIFIC MUTUAL
063	199	HARTFORD INSURANCE
064	199	PENN MUTUAL
065	199	PHILADELPHIA AMERICAN LIFE
066	094	PHYSICIANS MUTUAL/LIFE
067	165	PROVIDENT LIFE AND ACCIDENT
068	171	PRUDENTIAL
069	199	RAILROAD RETIREMENT
070	199	RELIANCE INSURANCE
071	105	AETNA HEALTH PLANS
072	199	RELIASTAR
073	199	STATE MUTUAL INSURANCE
074	199	SECURITY MUTUAL
075	199	SENTRY INSURANCE
076	199	MONARCH LIFE
077	175	TRAVELERS INSURANCE
078	199	UNION LABOR LIFE
079	199	UNION MUTUAL BENEFITS
081	199	U.S. LIFE
082	199	VETERANS ADMINISTRATION
083	181	WASHINGTON NATIONAL
084	199	WELLMARK COMMUNITY INSURANCE

CARRIER CODE	PAYOR CODE	INSURER NAME
085	199	OMNICARE
086	093	MAGNACARE (THRU LOCAL 274)
087	049	HIP
088	199	FIRST HEALTH
089	045	HIP HEALTH PLAN OF NEW JERSEY
091	047	HMO BLUE (BC/BS OF NJ)
092	058	PRUCARE
093	056	CO-MED HMO (CIGNA)
094	048	AETNA/US HEALTHCARE HMO
096	199	ST. BARNABAS SYSTEM HEALTH PLAN
098	031	PATIENT PAYMENT
099	199	OTHER INSURANCE
104	082	AETNA MEDICARE
105	082	AMERIHEALTH HMO, INC
106	082	CIGNA HEALTHCARE OF SOUTHERN NJ, INC
107	082	CIGNA HEALTHCARE OF NORTHERN NJ, INC
108	082	Q MED CARE (MEDICARE HMO)
109	082	HORIZON MEDICARE BLUE
110	082	OXFORD HEALTH PLANS (NJ) INC.
111	082	UNITED HEALTHCARE OF NEW JERSEY, INC
112	082	AMERICHOICE (MEDICARE HMO)
113	082	KEYSTONE (SENIOR BLUE)
114	082	UNITED HEALTHCARE MEDICARE COMPLETE (HMO)
115	082	HUMANA MEDCARE HMO PLAN
116	082	EMPIRE MEDICARE HMO BC/BS
117	082	SENIOR PARTNERS/HEALTH PARTNERS INC.
118	082	KAISER PERMANENTE (MEDICARE HMO)
119	082	STERLING LIFE (MEDICARE HMO)
120	082	WELLCARE (MEDICARE HMO ONLY)
121	082	AMERIGROUP (MEDICARE HMO)
122	082	ADVANTRA FREEDOM (MEDICARE HMO)
123	082	HEALTHFIRST NJ
124	082	SECURE HORIZONS (MEDICARE HMO)
125	082	TODAY'S OPTIONS (MEDICARE HMO)
126	082	UNICARE (MEDICARE HMO)
127	082	EVERCARE (MEDICARE HMO)
128	082	BRAVO HEALTH (MEDICARE HMO)
132	082	MEDICARE HMO (OUT OF STATE CARRIERS)

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Appendix D

Insurance Carrier Codes - Alphabetical

CARRIER CODE	PAYOR CODE	INSURER NAME
008	107	AARP CLAIMS
122	082	ADVANTRA FREEDOM (MEDICARE HMO)
071	105	AETNA HEALTH PLANS
104	082	AETNA MEDICARE
006	105	AETNA US HEALTHCARE
094	048	AETNA/US HEALTHCARE HMO
004	029	ALL OTHER BC/BS (DO NOT USE)
005	091	ALL UNION LOCAL INSURANCE
007	186	ALLSTATE
009	199	AMERICAN GENERAL INSURANCE
010	199	AMERICAN NATIONAL
112	082	AMERICHOICE (MEDICARE HMO)
121	082	AMERIGROUP (MEDICARE HMO)
105	082	AMERIHEALTH HMO, INC
054	195	APWU/AMERICAN POSTAL WORKERS UNION
025	125	AXA EQUITABLE
001	280	BC/BS OF NEW JERSEY
002	303	BC/BS OF NEW YORK (NEW YORK CITY)
003	362	BC/BS OF PHILADELPHIA
012	199	BENEFIT TRUST LIFE
128	082	BRAVO HEALTH (MEDICARE HMO)
017	199	CAN
043	199	CAPITAL ENTERPRISES, INC.
020	115	CIGNA (CONNECTICUT GENERAL)
034	074	CIGNA HEALTHCARE HMO
107	082	CIGNA HEALTHCARE OF NORTHERN NJ, INC
106	082	CIGNA HEALTHCARE OF SOUTHERN NJ, INC
018	199	COLONIAL LIFE AND ACCIDENT
047	199	COLONIAL PENN
019	199	COLUMBIA LIFE INSURANCE
093	056	CO-MED HMO (CIGNA)
022	120	CONTINENTAL ASSURANCE
116	082	EMPIRE MEDICARE HMO BC/BS
024	199	EMPLOYER'S HEALTH INSURANCE
026	125	EQUITABLE
127	082	EVERCARE (MEDICARE HMO)
027	022	FEDERAL BLUE CROSS
052	199	FEDERAL EXPRESS

CARRIER CODE	PAYOR CODE	INSURER NAME
028	199	FIREMAN'S FUND
088	199	FIRST HEALTH
029	199	GARDEN STATE HOSPITALIZATION NJ
030	199	GHI CLAIMS DEPARTMENT
031	199	GREAT WEST LIFE & ANNUITY
032	131	GUARDIAN LIFE/HEALTHNET
063	199	HARTFORD INSURANCE
123	082	HEALTHFIRST NJ
014	014	HEALTHNET TRICARE NORTHERN REGION
087	049	HIP
033	046	HIP HEALTH PLAN OF NEW JERSEY
089	045	HIP HEALTH PLAN OF NEW JERSEY
091	047	HMO BLUE (BC/BS OF NJ)
109	082	HORIZON MEDICARE BLUE
115	082	HUMANA MEDCARE HMO PLAN
035	199	INDEPENDENT LIFE
037	194	INTER COUNTY HEALTH PLAN
036	135	INTERCONTINENTAL
038	142	JOHN HANCOCK L.I.C. NOW UNICARE
118	082	KAISER PERMANENTE (MEDICARE HMO)
113	082	KEYSTONE (SENIOR BLUE)
039	199	LIBERTY MUTUAL
040	199	LIFE INSURANCE CORP., OA
059	199	LOCAL 798 WELFARE FUND
086	093	MAGNACARE (THRU LOCAL 274)
042	198	MAIL HANDLERS BENEFIT PLAN
044	145	MASSACHUSETTS MUTUAL
132	082	MEDICARE HMO (OUT OF STATE CARRIERS)
045	151	METROPOLITAN
076	199	MONARCH LIFE
048	199	MUTUAL BENEFIT
049	187	MUTUAL OF NEW YORK
050	155	MUTUAL OF OMAHA
051	188	NATIONAL ASSOCIATION OF LETTER CARRIERS
053	199	NATIONAL MARITIME UNION
057	161	NEW YORK LIFE/NYLCARE
058	199	NEW YORK SHIPPING ASSOCIATION
060	199	NORTHWESTERN NATION LIFE
061	199	OCCIDENTAL LIFE INSURANCE
085	199	OMNICARE
099	199	OTHER INSURANCE

CARRIER CODE	PAYOR CODE	INSURER NAME
110	082	OXFORD HEALTH PLANS (NJ) INC.
062	199	PACIFIC MUTUAL
098	031	PATIENT PAYMENT
064	199	PENN MUTUAL
013	199	PEOPLES BENEFIT INSURANCE
065	199	PHILADELPHIA AMERICAN LIFE
066	094	PHYSICIANS MUTUAL/LIFE
011	199	PRINCIPLE FINANCIAL GROUP
067	165	PROVIDENT LIFE AND ACCIDENT
092	058	PRUCARE
068	171	PRUDENTIAL
108	082	Q MED CARE (MEDICARE HMO)
046	096	QUALCARE PROVIDER
069	199	RAILROAD RETIREMENT
070	199	RELIANCE INSURANCE
072	199	RELIASTAR
124	082	SECURE HORIZONS (MEDICARE HMO)
074	199	SECURITY MUTUAL
117	082	SENIOR PARTNERS/HEALTH PARTNERS INC.
075	199	SENTRY INSURANCE
096	199	ST. BARNABAS SYSTEM HEALTH PLAN
073	199	STATE MUTUAL INSURANCE
119	082	STERLING LIFE (MEDICARE HMO)
125	082	TODAY'S OPTIONS (MEDICARE HMO)
077	175	TRAVELERS INSURANCE
081	199	U.S. LIFE
126	082	UNICARE (MEDICARE HMO)
023	199	UNION FIDELITY LIFE INS.
078	199	UNION LABOR LIFE
079	199	UNION MUTUAL BENEFITS
114	082	UNITED HEALTHCARE MEDICARE COMPLETE (HMO)
111	082	UNITED HEALTHCARE OF NEW JERSEY, INC
015	199	UNITY MUTUAL LIFE
082	199	VETERANS ADMINISTRATION
041	199	VIRGINIA HEALTH NETWORK
083	181	WASHINGTON NATIONAL
120	082	WELLCARE (MEDICARE HMO ONLY)
084	199	WELLMARK COMMUNITY INSURANCE

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Appendix E
Request For Electronic Funds Transfer (EFT)

See attached Authorization Agreement for automatic payments/deposits form. Reference **Section 8** for explanation and instructions.

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AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS

I (we) hereby authorize Gainwell Technologies, acting as Fiscal Agent for the State of New Jersey, Division of Medical Assistance and Health Services, to initiate credit entries to my (our) checking account and the depository bank indicated below, hereinafter called Depository, to credit the same to such account.

DEPOSITORY NAME _____ **BRANCH** _____

CITY _____ **STATE** _____ **ZIP** _____

BANK TRANSIT/ABA NO _____ **ACCOUNT NO.** _____

This authority is to remain in effect until the Fiscal Agent has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Fiscal Agent a reasonable opportunity to act on it.

BANK ACCOUNT NAME _____
(Print account name exactly as it appears on your statement)

PROVIDER NAME _____

PROVIDER NO. _____ **TELEPHONE NO.** _____

NPI # _____

ADDRESS _____

_____

_____ _____ **DATE** ___/___/___
Printed Name Signature

_____ _____ **DATE** ___/___/___
Printed Name Signature

REMARKS _____

_____

NOTES:

1. To insure accuracy of the bank account numbers, it is imperative that you attach a **BLANK, VOIDED CHECK** verifying the above bank ABA and account numbers.
2. If a joint account, both owners must sign request form.
3. New Jersey Medicaid payments are deposited to your account each Friday at 9:00 a.m.
4. Once Gainwell Technologies has received a **completed** authorization for payments/deposits, it will take approximately 4 weeks before the first deposit is completed electronically to your account. To verify this information, please call your bank and specifically ask for the **ACH Department**.
5. For those providers who previously had Direct Deposit, you will now receive paper checks until the new information is processed.
6. Please make a copy of this before mailing to Gainwell Technologies.

PROVIDER INSTRUCTIONS FOR COMPLETING AUTHORIZATION AGREEMENT FORM

1.	DEPOSITORY NAME	Name of bank servicing your checking account.
2.	BRANCH	Name of bank branch.
3.	CITY	City or town location of bank branch.
4.	STATE	State location of bank branch.
5.	ZIP	Zip code of bank branch.
6.	BANK TRANSIT/ABA NUMBER	Bank routing number (see below, voided check example).
7.	BANK ACCOUNT NUMBER	Checking account number (see below, voided check example).
8.	BANK ACCOUNT NAME	Actual account name per your bank's records.
9.	PROVIDER INFORMATION	Provider name, Medicaid/NJ FamilyCare Provider No., telephone No., address, date prepared and signature.

MAIL THE COMPLETED AUTHORIZATION AGREEMENT AND VOIDED CHECK TO:

Provider Enrollment Unit
Gainwell Technologies
P.O. Box 4804
Trenton, NJ 08650-4804

NOTE: Attach blank, voided check per below sample.