STATE OF NEW JERSEY

Department of Human Services
Division of Medical Assistance
and Health Services

NEW JERSEY MEDICAID MANAGEMENT INFORMATION SYSTEM (NJMMIS)

HOME HEALTH HOME CARE TRAINING

APRIL 2025

gainwell

AGENDA

INTRODUCTION TO GAINWELL TECHNOLOGIES

FORMS OF COMMUNICATION

Newsletters
Medicaid Alerts
Volume 23 No. 20

BENEFICIARY ELIGIBILITY

Medicaid Identification Number
Health Benefits Identification Card

PRIOR AUTHORIZATION (PA)

PA Request Form (FD-365)

CLAIM COMPLETION

1500
Place of Service Codes
Billing Other Insurance
UB-04 samples
Check Points
Return to Provider Form (RTP)
Claims Processing Flow

FINANCIAL TRANSACTION

Internal Control Number (ICN)
Julian Date Calendar (Perpetual)
Julian Date Calendar (Leap Year)
Remittance Advice (RA)
DMAHS Third Party Liability (TPL)
Medicare Buy-In

AGENDA

FORMS

Claim Correction Form (CCF)
CCF Quick Tips
Adjustments & FD-999
Common Reasons for Adjustments
Voids & FD-999
Adjustment/Void Processing Return to Provider Form
Claim Inquiry/Response Form
New Jersey MMIS Form Request

OTHER INFORMATION

Timely Filing
Fair Hearing
Managed Care Directory
MACC Directory
New Jersey County Social Service Agencies
P.O. Box Numbers
Phone Numbers
Gainwell Technologies at a Glance
NJMMIS Website

COMMUNICATION

NEWSLETTERS

What are Newsletters?

- A form of communication from the Division of Medical Assistance and Health Services (DMAHS), and used as a clarification of policy.
- To notify providers of changes and to help them understand the Medicaid policy and procedures.
- Newsletters are available on our website (www.njmmis.com). Supplement to the Provider Manual.

How to identify a Newsletter?

- Volume/Number/Date (month & year), categorized by provider type.
- First newsletter was distributed by Unisys (now Gainwell Technologies) in November of 1991 – Volume 1 No. 1. Example: DMAHS Newsletter, Volume 1, Number 1, November 1991.
- Each year the volume changes sequentially, but the number always starts with a # 1.
- Example: The first newsletter in 2002 was numbered – Volume 12 No. 1

NOTE:
All newsletters do not apply to "all" providers.

MEDICAID ALERTS

What are Medicaid Alerts?

- A form of communication from DMAHS and the Department of Health Services (DHS).
- To notify providers of changes and updates to the claims processing procedures.
- Used to fast track important policy and procedural changes to the providers.

How to identify a Medicaid Alert?

- Month and Year. Example: August, 2002.

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

NEWSLETTER

Volume 23 No. 20 **December 2013**

TO: All providers **– For Action**
Health Maintenance Organizations **– For Information Only**

SUBJECT: **NJ FamilyCare Expansion**

EFFECTIVE: Claims with service dates on or after January 1, 2014

PURPOSE: To notify NJ FamilyCare (NJFC) fee-for-service (FFS) providers of a State decision to expand the NJFC program to provide new opportunities for parents, single adults and childless couples to receive healthcare benefits from the NJFC program.

BACKGROUND: Beginning January 1, 2014, the Division of Medical Assistance and Health Services is expanding the NJFC program to offer healthcare to parents, single adults and childless couples ages 19 to 64, with incomes up to 133% of the Federal Poverty Level (FPL). Currently, the only childless adults covered by the State of New Jersey are those who qualify for the General Assistance (GA) program. Covered groups categorized as Aid to Families with Dependent Children (AFDC), Aged, Blind and Disabled, Long Term Care, and Juvenile Services programs are not impacted by the decision to expand NJFC. There is also no impact to benefits offered under NJFC Plans A, B, C, and D.

The new federal healthcare law requires the creation of an Alternative Benefit Plan (ABP) for the NJFC expansion population. The ABP includes all NJFC State Plan benefits with the exception of Long Term Services and Supports and includes some additional mental health and substance abuse services. The ABP will offer ten (10) essential health benefits including mental health and substance abuse, non-emergency transportation, prescriptions, and provide services for children referred to collectively as Early Prevention, Screening, Diagnosis and Treatment (EPSDT) services.

ACTION: **Effective January 1, 2014,** parents above Aid to Families with Dependent Children income requirements, single adults and childless couples shall be eligible to receive benefits under the ABP. For your convenience, a ***NJ FamilyCare/ABP Benefit Plan Comparison Chart*** is attached describing the eligible benefits under each of the NJFC plans, as well as the ABP (**See Attachment A**). It is important to note that the State will no longer offer NJFC Plan G or NJFC Plan D benefits for General Assistance beneficiaries or parents, respectively. These population groups will be eligible to receive healthcare benefits under the ABP.

Also attached, as **Attachment B,** is a poster, entitled NJ FamilyCare ***Expansion Program Quick Guide***, providing a brief description of eligibility and covered benefits under the ABP program.

The ABP will be available as a single plan for new parents, single adults and childless couples, ages 19 to 64 up to 133% of the FPL and will not include a long term care benefit. Claims for mental health, substance abuse and some family planning services shall be paid FFS by the NJFC program, regardless of the beneficiary's enrollment in managed care. Non-emergency transportation services shall be provided by LogistiCare, the State's medical transportation broker.

- ABP-covered benefits, with the exception of mental health and substance abuse services, shall be provided by NJFC-participating health maintenance organizations (HMOs). For those beneficiaries whose enrollment in managed care is in process, ABP benefits shall be provided by the NJFC FFS program until their enrollment in managed care has been finalized.

- ABP-eligible beneficiaries have no co-payment responsibilities related to covered benefits.

- Error Code 380 will continue to deny FFS claims when a covered benefit must be billed to an HMO.

ABP-eligible beneficiaries may directly contact providers or HMO member services to inquire regarding a provider's participation in an HMO provider network. If not currently enrolled in an HMO provider network, please call the appropriate managed care provider services telephone number listed below for information regarding provider applications and/or information regarding covered ABP benefits.

NJFC Managed Care Plans

Plan	Member Services	TTY	Provider Services
Amerigroup New Jersey, Inc.	1-800-600-4441	1-800-852-7899	1-800-454-3730
Healthfirst Health Plan of New Jersey, Inc.	1-888-464-4365	1-800-852-7897	1-866-889-2523
Horizon NJ Health	1-877-765-4325	1-800-654-5505	1-800-682-9091
United Healthcare Community Plan	1-800-941-4647	#711	1-888-362-3368
WellCare Health Plans, Inc.	1-888-453-2534	1-877-247-6272	1-866-687-8570 option 4

Single adults, childless couples and parents with questions regarding enrollment in the new NJFC Expansion Program may contact the NJFC Hotline at 1-800-701-0710 (TTY: 1-800-701-0720) or their County Welfare Agency.

Providers may continue to verify beneficiary eligibility, including those enrolled in the NJFC Expansion Program, by accessing either the Recipient Eligibility Verification System (REVS) (1-800-676-6562) or the Medicaid Eligibility Verification System (eMEVS) via www.njmmis.com.

If you have any questions concerning this Newsletter, please contact Molina Medicaid Solutions Provider Services at 1-800-776-6334.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

ATTACHMENT A

NJ FAMILYCARE/ABP BENEFIT PLAN COMPARISON CHART

Service Description	**Plan A**	**Plan B** *(Children under 19 years of age)*	**Plan C** *(Children under 19 year of age)*	**Plan D** *(Children under 19 years of age)*	**ABP**
Ambulatory Patient Services					
Primary Care ***(inclusive of physician, certified nurse practitioner/clinical nurse specialists)***	✓	✓	✓	✓	✓
Specialist Visits	✓	✓	✓	✓	✓
Outpatient Surgery	✓	✓	✓	✓	✓
Chiropractic Services ***(limited to spinal manipulation)***	✓	✓	✓	Not Covered	✓
Chemotherapy	✓	✓	✓	✓	✓
Radiation Therapy	✓	✓	✓	✓	✓
Anesthesia by Local Infiltration	✓	✓	✓	✓	✓
Free-Standing Ambulatory Clinic Services/ End Stage Renal Dialysis Services	✓	✓	✓	✓	✓
Access to Clinical Trials ***(limited to coverage of hospital costs for clinical trials)***	✓	✓	✓	✓	✓
Genetic Evaluation and Counseling	✓	✓	✓	✓	✓
Outpatient Diagnostic Labs, Radiology & Pathology	✓	✓	✓	✓	✓
Infertility Treatment Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dental Injury – Medical/Surgical Services of Dentist	✓	✓	✓	✓	✓
Dental – Diagnostic & Preventive ***(limitations apply)***	✓	✓	✓	✓	✓

Service Description	**Plan A**	**Plan B** *(Children under 19 years of age)*	**Plan C** *(Children under 19 year of age)*	**Plan D** *(Children under 19 years of age)*	**ABP**
Basic Dental Services	✓	✓	✓	✓	✓
Major Dental Services ***(prior authorization required; medically necessary Orthodontics, age limitations apply)***	✓	✓	✓	✓	✓
Acupuncture	✓	✓	✓	✓ ***(Covered when performed as a form of anesthesia in conjunction with approved surgery)***	✓
Federally Qualified Health Centers	✓	✓	✓	✓	✓
Abortion (Elective/Induced)	✓	✓	✓	✓	✓
Hospital Outpatient	✓	✓	✓	✓	✓
Ophthalmology Services	✓	✓	✓	✓	✓
TMJ Services	✓	✓	✓	Not Covered	✓
Emergency Services					
Emergency Room Services – Facility	✓	✓	✓	✓	✓
Ambulance Services	✓	✓	✓	✓	✓
Urgent Care Centers/Facilities	✓	✓	✓	✓	✓
Emergency Room Services – Physician	✓	✓	✓	✓	✓
Hospitalization					
Inpatient Medical and Surgical Care ***(prior authorization required for cosmetic surgery)***	✓	✓	✓	✓	✓
Inpatient – Religious Non-Medical Services (Christian Science Sanitaria Care)	✓	Not Covered	Not Covered	Not Covered	✓
Bariatric Surgery	✓	✓	✓	✓ Covered if pre-approved by HMO	✓
Organ & Tissue Transplants	✓	✓	✓	✓	✓
Chemotherapy Services	✓	✓	✓	✓	✓

Service Description	**Plan A**	**Plan B** *(Children under 19 years of age)*	**Plan C** *(Children under 19 year of age)*	**Plan D** *(Children under 19 years of age)*	**ABP**
Radiation Therapy	✓	✓	✓	✓	✓
Anesthesia	✓	✓	✓	✓	✓
Breast Reconstruction	✓	✓	✓	✓	✓
Hospice	✓	✓	✓	✓ ***(Limited to non-nursing facility based)***	✓
Anesthesia by Local Infiltration	✓	✓	✓	✓	✓
Blood and Blood Plasma	✓	✓	✓	Not Covered	✓
Blood Processing Administrative Cost	✓	✓	✓	✓	✓
Maternity and Newborn Care					
Pre- & Postnatal Care Maternity Services	✓	✓	✓	✓	✓
Delivery & Inpatient Maternity Services	✓	✓	✓	✓	✓
HealthStart	✓	✓	✓	✓	Not covered
Midwifery Services (Maternity)	✓	✓	✓	✓	✓
Newborn Child Coverage	✓	✓	✓	✓	✓
Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment					
Inpatient Medical Detox	✓	✓	✓	✓ ***(limited to detoxification for alcoholism)***	✓
Non-Medical Detoxification	Not Covered	Not Covered	Not Covered	Not Covered	✓
Substance Use Disorder Partial Care	Not Covered	Not Covered	Not Covered	Not Covered	✓
Substance Use Disorder Outpatient	Not Covered	Not Covered	Not Covered	Not Covered	✓
Substance Use Disorder Intensive Outpatient	Not Covered	Not Covered	Not Covered	Not Covered	✓

Service Description	**Plan A**	**Plan B** ***(Children under 19 years of age)***	**Plan C** ***(Children under 19 year of age)***	**Plan D** ***(Children under 19 years of age)***	**ABP**
Substance Use Disorder Halfway House	Not Covered	Not Covered	Not Covered	Not Covered	✓
Substance Use Disorder Short Term Residential	Not Covered	Not Covered	Not Covered	Not Covered	✓
Community Support Services (Effective 7/1/14)	✓	Not Covered	Not Covered	Not Covered	✓
Behavioral Health Home	✓	✓	✓	Not Covered	✓
Mental Health Outpatient	✓	✓	✓	✓	✓
Adult Mental Health Rehabilitation (group homes)	✓	Not Covered	Not Covered	Not Covered	✓
Inpatient Psychiatric Services	✓	✓	✓	✓	✓
Methadone Maintenance	✓	✓	✓	✓	✓
Psychiatrist, Psychologist or APN	✓	✓	✓	✓	✓
Partial Care ***(prior authorization required; 25 hour per week limit)***	✓	✓	✓	✓	✓
Medical Detoxification	✓	✓	✓	✓	✓
PACT	✓	Not Covered	Not Covered	Not Covered	✓
Psychiatric Emergency Services/Affiliated Emergency Services	Not Covered	Not Covered	Not Covered	Not Covered	✓
Case Management (Chronic Mental Illness)	✓	Not Covered	Not Covered	Not Covered	✓
Psychiatric Hospital - Inpatient	✓	✓	✓	✓	✓
Clinic Services (free-standing) Mental Health ***(prior authorization required for psychotherapy beyond financial threshold of $900)***	✓	✓	✓	✓	✓

Service Description	**Plan A**	**Plan B** *(Children under 19 years of age)*	**Plan C** *(Children under 19 year of age)*	**Plan D** *(Children under 19 years of age)*	**ABP**
Partial Hospital ***(prior authorization required for acute Partial Hospital only; Partial Hospital- limit of 2 years)***	✓	✓	✓	✓	✓
Residential Treatment Center Services ***(prior authorization required, limited to under 21 years of age)***	✓	Not Covered	Not Covered	Not Covered	✓
Outpatient Hospital/Clinic Services and Physician	✓	✓	✓	✓	✓
Inpatient Hospital/Clinic Services	✓	✓	✓	✓	✓
Inpatient Physician	✓	✓	✓	✓	✓
Prescription Drugs					
Retail Pharmacy	✓	✓	✓	✓	✓
Mail Order Pharmacy	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptives	✓	✓	✓	✓	✓
Methadone Maintenance (Clinic Service Only)	✓	✓	✓	Not Covered	✓
Anti-Retroviral Drugs	✓	✓	✓	✓	✓
Antipsychotic Drugs, Including Atypicals	✓	✓	✓	✓	✓
Mental Health/Substance Abuse Drugs	✓	✓	✓	✓	✓
Over-the-Counter Drugs	✓	✓	✓	Not Covered	✓
Physician-Administered Drugs	✓	✓	✓	✓	✓
Hemophiliac Drugs	✓	✓	✓	Not Covered	✓
Suboxone® and Related Drug Products	✓	✓	✓	✓	✓
Infusion Therapy	✓	✓	✓	✓	✓
Specialty Drugs	✓	✓	✓	✓	✓
Rehabilitative and Habilitative Services and Devices					

Service Description	**Plan A**	**Plan B** *(Children under 19 years of age)*	**Plan C** *(Children under 19 year of age)*	**Plan D** *(Children under 19 years of age)*	**ABP**
Physical, Speech, & Occupational Therapies	✓	✓ *(limits apply)*	✓ *(limits apply)*	✓ *(limits apply)*	✓
Intermediate Care Facility for Persons with Intellectual Disability(ICF/ID)	✓	Not Covered	Not Covered	Not Covered	Not covered
Cardiac Rehabilitation	✓	✓	✓	✓	✓
Pulmonary Rehabilitation	✓	✓	✓	✓	✓
Medically Necessary Durable Medical Equipment and Medical Supplies	✓	✓	✓	✓ *(Limited to certain DME services that could prevent costly future inpatient admissions)*	✓
Durable Medical Equipment with Vision Impairment	✓	✓	✓	Not Covered	✓
Optical Appliances	✓ *(Limited to once every two years)*	✓ *(Limits apply)*	✓ *(Limits apply)*	✓ *(Limited to one pair of glasses or contact lenses per 24-month period or as medically necessary)*	✓ *(Limited to once every two years)*
Hearing Aid Services	✓ *(Limited to one device per client)*	✓ *(Limits apply)*	✓ *(Limits apply)*	✓ *(Only covered for children 15 years of age or younger)*	✓ *(Limited to one device per client)*
Prosthetics *(Prior authorization required)*	✓	✓	✓	✓ *(Limited to initial provision of device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect)*	✓

Service Description	***Plan A***	***Plan B*** ***(Children under 19 years of age)***	***Plan C*** ***(Children under 19 year of age)***	***Plan D*** ***(Children under 19 years of age)***	***ABP***
Orthotics ***(Prior authorization required)***	✓	✓	✓	Not Covered	✓
Home Health Care-Non Rehab (i.e. Skilled Nursing, Home Health Aide)	✓	✓	✓	✓	✓
Home Health Care-Rehab (i.e. PT, OT & Speech Therapies)	✓	✓ ***(Limits apply)***	✓ ***(Limits apply)***	✓ ***(Limits apply)***	✓
Personal Care Assistant ***(Limit of 40 hours per week)***	✓	Not Covered	Not Covered	Not Covered	✓
Partial Care ***(Limit of 5 hours per day, 25 hours per week)***	✓	✓	✓	✓	✓
Medical Day Care-Adult ***(must be at least 5 hours per day, 5 days per week)***	✓	Not Covered	Not Covered	Not Covered	✓
Nursing Facility-Skilled Nursing Facility	✓	✓ ***(Skilled nursing and/or rehabilitation care provided; custodial care not covered.)***	✓ ***(Skilled nursing and/or rehabilitation care provided; custodial care not covered.)***	Not Covered	✓ ***(Skilled nursing and/or rehabilitation care provided; custodial care not covered.)***
Laboratory Services					
Lab tests, x-ray services & pathology	✓	✓	✓	✓	✓
Thermograms and Thermography	✓	✓	✓	Not Covered	✓
Imaging/diagnostics (e.g. MRI, CT Scan, PET Scan)	✓	✓	✓	✓	✓
Preventive and Wellness Services and Chronic Disease Management					
Preventive Care/Early Intervention	✓	✓	✓	✓	✓
Immunizations	✓	✓	✓	✓	✓
Colorectal Cancer Screening	✓	✓	✓	✓	✓
Service Description	***Plan A***	***Plan B*** ***(Children under 19 years of age)***	***Plan C*** ***(Children under 19 year of age)***	***Plan D*** ***(Children under 19 years of age)***	***ABP***

Service Description	***Plan A***	***Plan B*** ***(Children under 19 years of age)***	***Plan C*** ***(Children under 19 year of age)***	***Plan D*** ***(Children under 19 years of age)***	***ABP***
Screening Mammography	✓	✓	✓	✓	✓
Optometrist Services	✓	✓	✓	✓ ***(Limited to one per year)***	✓
Nutritional Counseling	✓	✓	✓	✓	✓
Smoking Cessation Program	✓	✓	✓	✓	✓
Allergy Testing & Injections	✓	✓	✓	✓	✓
Family Planning ***(includes free-standing clinics)***	✓	✓	✓	✓	✓
Diabetes-Medically Necessary Equipment & Supplies	✓	✓	✓	✓	✓
Screening Pap Tests	✓	✓	✓	✓	✓
Routine Gynecological Exam	✓	✓	✓	✓	✓
Annual Prostate Cancer Screening for Men 50-72 yrs	✓	✓	✓	✓	✓
Midwifery Services (Non-Maternity)	✓	✓	✓	✓	✓
Podiatry Services ***(routine care not covered)***	✓	✓	✓	✓	✓
Pediatric Services, Including Oral and Vision Care					
EPSDT	✓	✓	✓	✓ ***(Limited to well child care only)***	✓
School-based Services	✓	Not Covered	Not Covered	Not Covered	✓
Private Duty Nursing ***(Prior Authorization required)***	✓ ***(limited to children under 21)***	✓	✓	✓	✓ ***(limited to children under 21)***
Miscellaneous					
Non-Emergency Transportation	✓ ***(Includes livery)***	✓	✓	Not Covered	✓ ***(Includes livery)***

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

*** * * PLEASE POST * * ***

NJ FamilyCare Expansion Program Quick Guide

Effective on or after January 1, 2014, the following groups of individuals may enroll in a NJ FamilyCare (NJFC) Managed Care Plan in order to receive healthcare benefits provided through the NJFC Expansion Program.

- Single Adults up to133% of the Federal Poverty Level (FPL)
- Childless Couples up to 133% of the FPL

Healthcare benefits under the expansion program shall be provided by a NJFC-participating Managed Care Plan. Covered benefits include:

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Prescription Drugs
- Rehabilitative and Habilitative Services and Devices
- Laboratory Services
- Preventative and Wellness Services and Chronic Disease Management
- Pediatric Services, including Oral and Vision Care

Mental Health and Substance Abuse Services shall be provided by the NJFC Fee-For-Service program.

NJFC Managed Care Member Services

Providers may also access the State's Recipient Eligibility Verification System (REVS) by telephone (1-800-676-6562) or through eMEVS found at www.njmmis.com.

NJFC-participating Managed Care Plans

Plan	Member Services	TTY	Provider Services
AmeriGroup NJ, Inc.	1-800-600-4441	1-800-852-7899	1-800-454-3730
Healthfirst Health Plan of NJ, Inc.	1-888-464-4365	1-800-852-7897	1-866-889-2523
Horizon NJ Health	1-877-765-4325	1-800-654-5505	1-800-682-9091
UnitedHealthcare Community Plan	1-800-941-4647	#711	1-888-362-3368
WellCare Health Plans, Inc.	1-888-453-2534	1-877-247-6272	1-866-687-8570 option 4

BENEFICIARY ELIGIBILITY

BENEFICIARY MEDICAID NUMBER

2	0	7	0	9	9	9	9	9	9	0	1

COUNTY

01	Atlantic
02	Bergen
03	Burlington
04	Camden
05	Cape May
06	Cumberland
07	Essex
08	Gloucester
09	Hudson
10	Hunterdon
11	Mercer
12	Middlesex
13	Monmouth
14	Morris
15	Ocean
16	Passaic
17	Salem
18	Somerset
19	Sussex
20	Union
21	Warren
23	FamilyCare
24	FamilyCare
25	Presumptively Eligible/FamilyCare
35	CSOC (formerly CSOCI/PFC, CBHS)

PROGRAM

10	Aged-SSI Related
15	Aged-Medically Needy
20	Disabled-SSI Related
25	Disabled-Medically Needy
30	Aid to Families with Dependent Children
35	Medically Needy Children and Pregnant Women
50	Blind-SSI Related
55	Blind-Medical Needy
60	Department of Children & Families (DCF)
70	Medical Assistance for Aged - State Program - MAA
80	Juvenile Services

CASE #

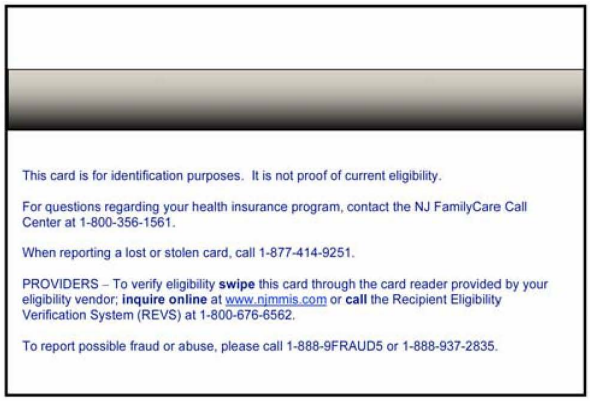
PERSON #

01	Adult
05	Unborn Child (Medicaid Only, Pregnant Women)
10	Essential Person
20-39	Children Under 21
40-47	Medicaid Special-Sibling within One Family Unit
48	Medicaid Special-Second Individual Sibling with 49 in a Marital Relationship
49	Medicaid Special-Single Individual

HSP# (Health Services Program) = 1st 10 digits

PIN (Personal Number) = 2 digit suffix

HEALTH BENEFITS IDENTIFICATION CARD

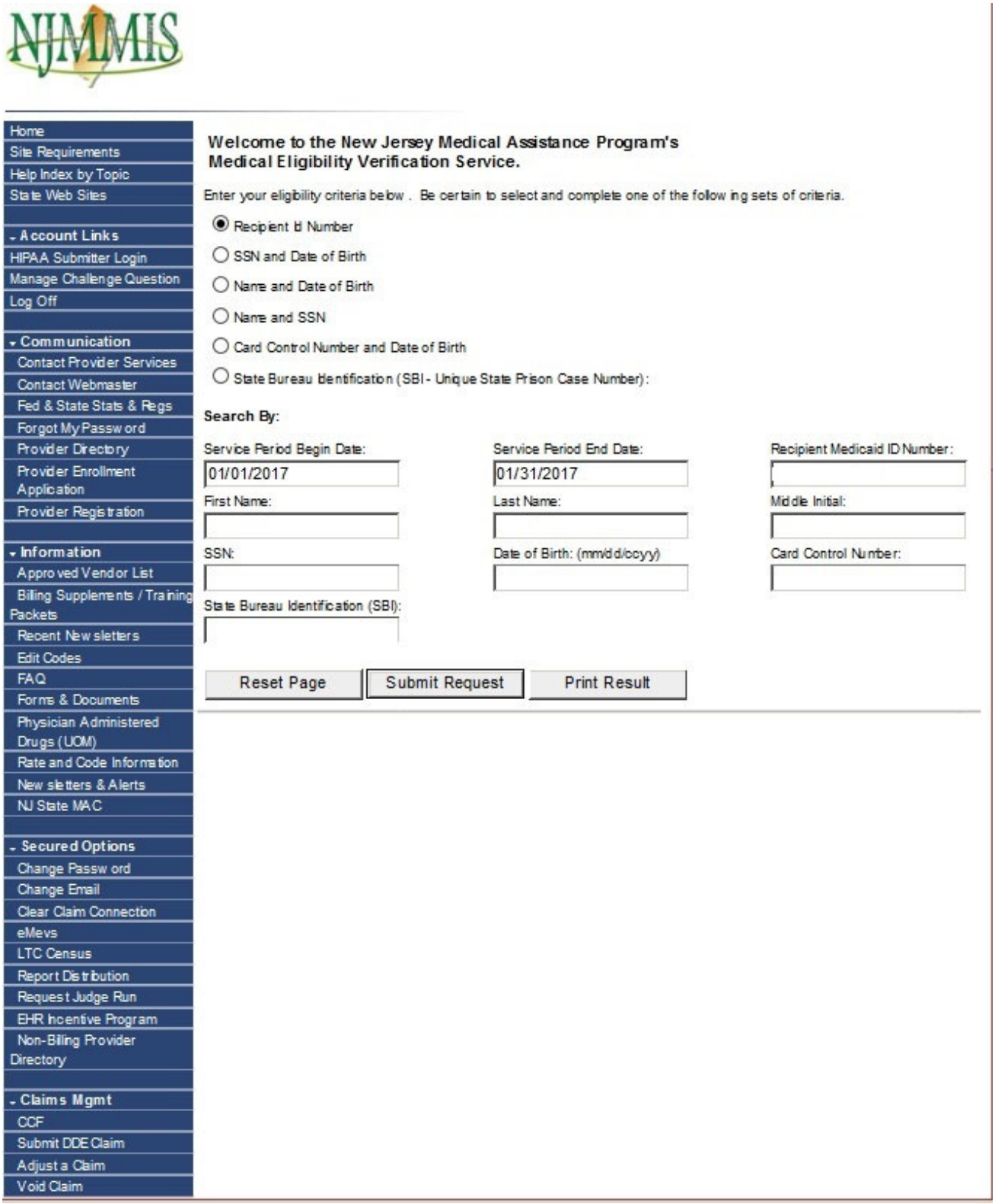


Key Facts About the HBID Card:

- Each family member will receive his or her own plastic identification card.
- The plastic card is PERMANENT.
- The card is for identification purposes only; ***providers must verify eligibility before rendering services***, even if a Prior Authorization has been received***.***
- In addition to using REVS (the automated eligibility line) and eMEVS (the Web-based eligibility verification system) optional use of magnetic swipe technology will allow providers quick and easy access to up to date client information.

Refer to Newsletter Volume 16 No. 12 for additional information

eMEVS


NJMMIS
Home
Site Requirements
Help Index by Topic
State Web Sites
Account Links
HIPAA Submitter Login
Manage Challenge Question
Log Off
Communication
Contact Provider Services
Contact Webmaster
Fed & State Stats & Regs
Forgot My Password
Provider Directory
Provider Enrollment Application
Provider Registration
Information
Approved Vendor List
Billing Supplements / Training Packets
Recent Newsletters
Edit Codes
FAQ
Forms & Documents
Physician Administered Drugs (UOM)
Rate and Code Information
Newsletters & Alerts
NJ State MAC
Secured Options
Change Password
Change Email
Clear Claim Connection
eMevs
LTC Census
Report Distribution
Request Judge Run
EHR Incentive Program
Non-Billing Provider Directory
Claims Mgmt
CCF
Submit DDE Claim
Adjust a Claim
Void Claim
Welcome to the New Jersey Medical Assistance Program's Medical Eligibility Verification Service.
Enter your eligibility criteria below . Be certain to select and complete one of the following sets of criteria.
Recipient Id Number
SSN and Date of Birth
Name and Date of Birth
Name and SSN
Card Control Number and Date of Birth
State Bureau Identification (SBI - Unique State Prison Case Number):
Search By:
Service Period Begin Date:
01/01/2017
Service Period End Date:
01/31/2017
Recipient Medicaid ID Number:
First Name:
Last Name:
Middle Initial:
SSN:
Date of Birth: (mm/dd/ccyy)
Card Control Number:
State Bureau Identification (SBI):
Reset Page
Submit Request
Print Result

Results as of 1/12/2017 11:33 AM:

Last Name:		First Name:	Middle Initial:
Submitted Recipient Id #:		Eligible:	Yes
Date of Birth:		SSN:	
Card Control Number:			
Submitted SBI:			
Submitted Begin Date:	01/01/2017	Submitted End Date:	01/31/2017
Hospice Message:			

Medicaid Eligibility Data:

Begin Date:	3/1/2016	End Date:	1/31/2017
Recipient Id # for Billing:			
Message:	NJ FAMILYCARE PLAN A BP, REFER TO NJMMIS.COM FOR NEWSLETTERS VOL.23 NO.20, VOL.25 NO.12; COVERED FOR SUBSTANCE USE DISORDER TREATMENT. REFER TO NJMMIS.COM FOR NEWSLETTER VOL.26 NO.06		
Eligible Services:	1-Medical Care	33-Chiropractic	35-Dental Care
	45-Hospice	47-Hospital	48-Inpatient Hospital
	50-Outpatient Hospital	86-Emergency Services	88-Pharmacy
	98-Physician Visits	AL-Vision	MH-Mental Health
	UC-Urgent Care		
Termination Message:			
County of Supervision:	023	County Name:	NJ FamilyCare Vendor

Medicaid Recipient Lockin Data:

Lockin Begin Date:		Lockin End Date:	
Message:			

Medicaid Special Program Data:

Begin Date:		End Date:	
Message:			
Special Pgm Code:			

Medicaid Managed Care Data:

MCO Name:	UNITEDHEALTHCARE	MCO Phone Number:	
Begin Date:	7/1/2016	End Date:	1/31/2017
MCO Patient ID Number:		Plan Code:	
Message:			

Medicare Part A Data:

Begin Date:		End Date:	
HIC Number:			

Medicare Part B Data:

Begin Date:		End Date:	
HIC Number:			

Medicare Part D Data:

Start Date:		End Date:	
Contract Number:		Plan Id:	
Name:		Policy Number:	
Group Number:		NJ Insurer Code:	
Copay Level:			

Commercial Third Party Coverage Data:

Begin Date:	1/1/2015	End Date:	1/31/2017
Policy Number:		Group Number:	
Carrier Name:	MERCK-MEDCO		
Message:	THE BENERCIARY HAS COVERAGE WITH ANOTHER INSURER. CONTACT THE INSURER FOR DETAILS ON COVERAGE OR BENERTS		

Commercial Third Party Coverage Data:

Begin Date:	1/1/2015	End Date:	1/31/2017
Policy Number:		Group Number:	
Carrier Name:	UNITED HEALTHCARE		
Message:	THE BENERCIARY HAS COVERAGE WITH ANOTHER INSURER. CONTACT THE INSURER FOR DETAILS ON COVERAGE OR BENERTS		

PRIOR AUTHORIZATION (PA)

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

PRIOR AUTHORIZATION REQUEST

PA# 15 00134193

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number
DAVIS	**JOE**		**643 AMBOY ROAD**	**609-555-6893**

3. HSP (Medicaid) Case No.	4. Person No.	5. Date of Birth	6. Sex	City	State	ZIP Code
0765349354	**01**	**MMDDYY**	☒ Male ☐ Female	**WESTBORO**	**NJ**	**64080**

7. Remarks:

"Weighted" score determined by your evaluation of need

8. **PROVIDER OF SERVICE INFORMATION**

Telephone Number: **609-555-7000**

Medicaid Provider Number (Enter only when not printed below): **1234567**

Names and Address

PERSONAL HOME CARE
45 SOUTH 19 TH STREET
WESTBORO, NJ 64080

9. DIAGNOSIS

MULTIPLE SCLEROSIS

10. PROPOSED TREATMENT PLAN

PCA CARE

25 HOURS PER CALENDAR WEEK SUNDAY - SATURDAY

11. REQUESTED DATE(S)	12. AUTHORIZED DATE(S)	13. Reviewer ID / Review Date
From: **07-04-24** Thru: **09-03-24**	From: Thru:	

14. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 8 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
	S9122		**542**				**HR-WEEKDAY**				
	S9122TV		**40**				**HR-WEEKEND**				

FD-365 (Rev 9/91) **FISCAL AGENT COPY** Medicaid Part 1 of 2

CLAIM COMPLETION

HEALTH INSURANCE CLAIM FORM

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

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): **123456789001**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **DAVIS JOE**

3. PATIENT'S BIRTH DATE SEX: MM DD YY — **MM DD YY** M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): **123 SOMEPLACE WAY**

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: **ANYTOWN** STATE: **NJ**

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: **12345** TELEPHONE (Include Area Code): **(609)555-5555**

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? ☐ YES ☒ NO PLACE (State)

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 **SIGNATURE ON FILE** DATE: **01/01/24**

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. **G2** 1234567

17b. NPI 1234567891

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. **0**

A. **Z206** B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: **1512345678**

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	07	01	24	07	01	24	12		S9122		A	1550	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.: **123**

27. ACCEPT ASSIGNMENT? (FOR GOVT. CLAIMS, SEE BACK) ☐ YES ☐ NO

28. TOTAL CHARGE: $ **1550**

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 **I M A BILLER** DATE **07/15/24**

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33 BILLING PROVIDER INFO & PH # **(609)555-1234**

PERSONAL HOME CARE
45 SOUTH LANE
ANYTOWN, NJ 12345

a. **1234567890** b. **G2 1234567**

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

HEALTH INSURANCE CLAIM FORM

2024076100060

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

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): 123456789001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DAVIS JOE

3. PATIENT'S BIRTH DATE SEX: MM DD YY MM DD YYYY 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 SEX: MM DD YY 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. G2 1234567

17b. NPI 1234567891

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. 0

A. Z206 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1512345678

	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	10	01	24	10	01	24	12		S9122		A	1550	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. 123

27. ACCEPT ASSIGNMENT? (FOR GOVT. CLAIMS, SEE BACK) ☐ YES ☐ NO

28. TOTAL CHARGE $ 1550

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 I M A BILLER DATE 10/15/24

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33 BILLING PROVIDER INFO & PH # ( )

a. 1234567890 b. G2 1234567

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PLACE OF SERVICE CODES (1500)

NJMMIS SYSTEM VALUES	EDI/DDE/PAPER VALUES
0 – Emergency Room	23 – Emergency Room – Hospital
1 – Doctor's Office	11 – Office
2 – Patient's Home	12 – Home
3 – Inpatient Hospital	21 – Inpatient Hospital
	51 – Inpatient Psychiatric Facility
	61 – Comprehensive Inpatient Rehabilitation Facility
4 – Boarding Home	14 – Group Home
	33 – Custodial Care Facility
5 – Skilled Nursing Home	31 – Skilled Nursing Facility
	32 – Nursing Facility
	54 – Intermediate Care Facility/Mentally Retarded
6 – Independent Laboratory	81 – Independent Laboratory
7 – Outpatient Hospital	19 – Outpatient Hospital – Off Campus
	22 – Outpatient Hospital – On Campus
	52 – Psychiatric Facility Partial Hospitalization
	62 – Comprehensive Outpatient Rehabilitation Facility
	65 – End Stage Renal Disease Treatment Facility
8 – Clinic	24 – Ambulatory Surgical Center
	25 – Birthing Center
	49 – Independent Clinic
	50 – Federally Qualified Health Center
	53 – Community Mental Health Center
	57 – Non-Residential Substance Abuse Treatment Facility
	60 – Mass Immunization Center
	71 – State or Local Public Health Clinic
	72 – Rural Health Clinic
9 – Other	01 – Pharmacy
	02 – Telehealth Provided Other Than in 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 Patient's Home
	13 – Assisted living facility
	15 – Mobile unit
	16 – Temporary Lodging
	17 – Walk – in retail health clinic
	18 – Place of employment – worksite
	20 – Urgent Care facility
	26 – Military Treatment Facility
	27 -- Outreach Site/Street
	34 – Hospice
	41 – Ambulance – Land
	42 – Ambulance – Air or Water
	55 – Residential Substance Abuse Treatment Facility
	56 – Psychiatric Residential Treatment Center
	99 – Other Unlisted Facility

BILLING OTHER INSURANCE

WRITTEN INSTRUCTIONS AFTER BILLING COMMERCIAL INSURANCE

Medicare/Medicaid

When billing **Medicare/Medicaid**, there are two (2) additional fields required on the claim form.

- **10d:** Print or type the three (3) digit Carrier Code. Refer to Appendix D of the billing supplement.
- **11d:** Print or type an "X" in the YES box.
- **Attach the Explanation of Medicare Benefits (EOMB)**

*** Do not include Medicare Payment in field 29.**

Commercial Insurance/Medicare HMO

When billing **Commercial Insurance/Medicare HMO**, there are four (4) additional fields required on the claim form.

- **10d:** Print or type the three (3) digit Carrier Code. Refer to Appendix D of the billing supplement.
- **11d:** Print or type an "X" in the YES box.
- **19:** Print or type any patient responsibility (sum of copay, deductible, coinsurance) amounts.
- **29:** Print or type the amount paid by the commercial insurance.
- **Attach the EOB**

1 Personal Homecare Inc.	2	3a PAT. CNTL #		4 TYPE OF BILL
1 Main Street		b MED. REC. #		323
Anytown NJ 12345		5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM 070124 THROUGH 073124	7.

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 3 Elm Street
b Doe Jane	b Anytown c NJ d 12345 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01251948	F																			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
551	Skilled Nursing		07/02/24	4	1031 46		
551	Skilled Nursing		07/0724	4	1031 46		
551	Skilled Nursing		07/30/24	4	1031 46		
001					3094 38		

PAGE 1 OF 1 CREATION DATE 073124 TOTALS 3094 38

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
012						57 OTHER PRV ID	1234567

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Doe Jane		123456789001		

63 TREATMENT AUTHORIZATION CODE	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX											68
	G119	R6250	F58.9	C	D	E	F	G	H		
0	I	J	K	L	M	N	O	P	Q		

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73
	G119	b	c		541	a	b	c		

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC				
	A				
Skilled Nursing	B				
	C				
	D				

76 ATTENDING	NPI 1234567890	QUAL 1D	1234567
LAST Smith		FIRST John	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI 1234567890	QUAL DN	1234567
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b MED. REC. #		323
		5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH 7.
			100124	103124

8 PATIENT NAME	9 PATIENT ADDRESS
b Doe Jane	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01251948	F																			

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
ICN: 2024031112345	a					
	b					
	c					
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
551	Skilled Nursing		10/02/24	4	1031.46		
551	Skilled Nursing		10/07/24	4	1031.46		
551	Skilled Nursing		10/30/24	4	1031.46		

PAGE 1 OF 1 ***CREATION DATE*** 103124 ***TOTALS*** 3094.38

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
012						57	1234567
						OTHER	
						PRV ID	

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Doe Jane		123456789001		

63 TREATMENT AUTHORIZATION CODE	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX											68
	G111	J81	I5021	C	D	E	F	G	H		
0	I	J	K	L	M	N	O	P	Q		

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73
	G111	b	c		541	a	b	c		

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC				
Skilled Nursing	a				
	b				
	c				
	d				

76 ATTENDING	NPI 1234567890	QUAL 1D	1234567
LAST Smith		FIRST John	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI 1234567890	QUAL DN	1234567
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

1 Personal Homecare Inc.	2	3a PAT. CNTL #		4 TYPE OF BILL
1 Main Street		b MED. REC. #		321
Anytown NJ 12345		5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM 020124 THROUGH 022824	7.

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 3 Elm Street
b Doe Jane	b Anytown c NJ d 12345 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
01251948	F									

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
A3	01/25/24													

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
	a D3	3094 38				
	b					
	c					
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
551	Skilled Nursing		02/02/24	4	1031 46		
551	Skilled Nursing		02/02/24	4	1031 46		
551	Skilled Nursing		02/30/24	4	1031 46		
001					3094 38		
			073124	TOTALS	3094 38		

PAGE 1 OF 1 CREATION DATE

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
011						57	123456
012						OTHER	1234567
						PRV ID	

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Doe Jane		123456789001		

63 TREATMENT AUTHORIZATION CODE	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	A	B	C	D	E	F	G	H	68
	G111	J81	I5021						
	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
	G111				541					

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC				
Skilled Nursing	a				
	b				
	c				
	d				

76 ATTENDING	NPI 1234567890	QUAL 1D	1234567
LAST Smith		FIRST John	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI 1234567890	QUAL DN	1234567
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

1 Personal Homecare Inc.	2	3a PAT. CNTL #		4 TYPE OF BILL
1 Main Street		b MED. REC. #		321
Anytown NJ 12345		5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM: 020124 THROUGH: 022824	7.

8 PATIENT NAME a	9 PATIENT ADDRESS a 3 Elm Street
b Doe Jane	b Anytown c NJ d 12345 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
01251948	F									

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A7	150.00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
551	Skilled Nursing		02/02/24	4	1031.46		
551	Skilled Nursing		02/07/24	4	1031.46		
551	Skilled Nursing		02/30/24	4	1031.46		
001					3094.38		
	PAGE 1 OF 1	**CREATION DATE**	073124	**TOTALS**	3094.38		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
082				550.75		57 123456
012						OTHER 1234567
						PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Doe Jane		123456789001		

63 TREATMENT AUTHORIZATION CODE	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX									68
	G111	J81	I5021	C	D	E	F	G	H
0	I	J	K	L	M	N	O	P	Q

69 ADMIT DX | 70 PATIENT REASON DX: G111 b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI 1234567890	QUAL 1D	1234567
LAST Smith		FIRST John	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI 1234567890	QUAL DN	1234567
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

Skilled Nursing

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

CHECK POINTS

- ☑ **Did you remember your NPI?**
- ☑ Are all of my Provider ID numbers in the correct field?
- ☑ Are all the required fields completed?
- ☑ Are my forms legible?
- ☑ Did I sign & date my claim?
- ☑ Did I address my envelope to the appropriate P.O. Box? (see reference page):
- ☑ Did you remember to list the appropriate Medicaid qualifier? Note: As of 4/1/14, the correct qualifier for the 1500 claim form is G2.

Remember, do not use highlighters on claims or attachments.

Remember original signatures only, no stamps, initials or computer generated signatures are acceptable on claims.

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.

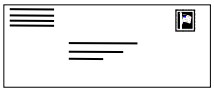
Rev. 01/21

CLAIMS PROCESSING FLOW

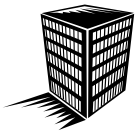
ADJUDICATED CLAIMS WILL APPEAR THE FOLLOWING WEEK

Paper Claims Submission
24 DAYS

The claim form is prepared.



The envelope is prepared and mailed.



The claim is received by Gainwell Technologies.

Claims are opened, sorted, screened, imaged, batched and routed.

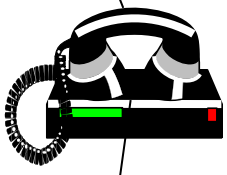
The claim is entered into the system by a data entry person.

The claim is received by our claims processing system.

VS

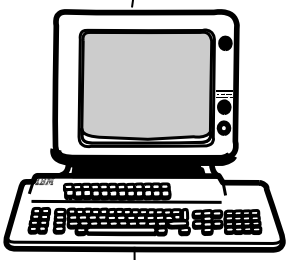
Electronic Claims Submission
Direct Data Entry (DDE)
7-10 DAYS

The claim is entered at your office and transmitted directly to Gainwell Technologies.



Only minutes of transmission time.

And no stops along the way.



The claim is received by our claims processing system.

Note: Some claims may take longer to process due to manual pricing.

Note: Paper claims received after 1/1/12 with no attachment will be returned to the provider. Please refer to Newsletter Volume 21 No. 25.

FINANCIAL TRANSACTION

INTERNAL CONTROL NUMBER (ICN)

24	**154**	**01**	**1234**	**01**
Receipt Year	**Receipt Julian Date**	**Roll Number**	**Sequence Number**	**Line Item**

01-09	Hardcopy Claims
10-12	Direct Data Entry (DDE)
20-37	EMC Crossovers
40-41	HMO Capitation
42-44	Transportation Capitation
46-47	LTC TADs
48-49	LTC Capitation
50-69	EMC Claims
80-84	Mass Adjustments
85-85	PR-1 LTC/Hospice Retro Adjustments
90-99	Financial Transactions

JULIAN DATE CALENDAR
(PERPETUAL)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	**1**
2	002	033	061	092	122	153	183	214	245	275	306	336	**2**
3	003	034	062	093	123	154	184	215	246	276	307	337	**3**
4	004	035	063	094	124	155	185	216	247	277	308	338	**4**
5	005	036	064	095	125	156	186	217	248	278	309	339	**5**
6	006	037	065	096	126	157	187	218	249	279	310	340	**6**
7	007	038	066	097	127	158	188	219	250	280	311	341	**7**
8	008	039	067	098	128	159	189	220	251	281	312	342	**8**
9	009	040	068	099	129	160	190	221	252	282	313	343	**9**
10	010	041	069	100	130	161	191	222	253	283	314	344	**10**
11	011	042	070	101	131	162	192	223	254	284	315	345	**11**
12	012	043	071	102	132	163	193	224	255	285	316	346	**12**
13	013	044	072	103	133	164	194	225	256	286	317	347	**13**
14	014	045	073	104	134	165	195	226	257	287	318	348	**14**
15	015	046	074	105	135	166	196	227	258	288	319	349	**15**
16	016	047	075	106	136	167	197	228	259	289	320	350	**16**
17	017	048	076	107	137	168	198	229	260	290	321	351	**17**
18	018	049	077	108	138	169	199	230	261	291	322	352	**18**
19	019	050	078	109	139	170	200	231	262	292	323	353	**19**
20	020	051	079	110	140	171	201	232	263	293	324	354	**20**
21	021	052	080	111	141	172	202	233	264	294	325	355	**21**
22	022	053	081	112	142	173	203	234	265	295	326	356	**22**
23	023	054	082	113	143	174	204	235	266	296	327	357	**23**
24	024	055	083	114	144	175	205	236	267	297	328	358	**24**
25	025	056	084	115	145	176	206	237	268	298	329	359	**25**
26	026	057	085	116	146	177	207	238	269	299	330	360	**26**
27	027	058	086	117	147	178	208	239	270	300	331	361	**27**
28	028	059	087	118	148	179	209	240	271	301	332	362	**28**
29	029		088	119	149	180	210	241	272	302	333	363	**29**
30	030		089	120	150	181	211	242	273	303	334	364	**30**
31	031		090		151		212	243		304		365	**31**
DAY	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**DAY**

LEAP YEAR JULIAN DATE CALENDAR

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	**1**
2	002	033	062	093	123	154	184	215	246	276	307	337	**2**
3	003	034	063	094	124	155	185	216	247	277	308	338	**3**
4	004	035	064	095	125	156	186	217	248	278	309	339	**4**
5	005	036	065	096	126	157	187	218	249	279	310	340	**5**
6	006	037	066	097	127	158	188	219	250	280	311	341	**6**
7	007	038	067	098	128	159	189	220	251	281	312	342	**7**
8	008	039	068	099	129	160	190	221	252	282	313	343	**8**
9	009	040	069	100	130	161	191	222	253	283	314	344	**9**
10	010	041	070	101	131	162	192	223	254	284	315	345	**10**
11	011	042	071	102	132	163	193	224	255	285	316	346	**11**
12	012	043	072	103	133	164	194	225	256	286	317	347	**12**
13	013	044	073	104	134	165	195	226	257	287	318	348	**13**
14	014	045	074	105	135	166	196	227	258	288	319	349	**14**
15	015	046	075	106	136	167	197	228	259	289	320	350	**15**
16	016	047	076	107	137	168	198	229	260	290	321	351	**16**
17	017	048	077	108	138	169	199	230	261	291	322	352	**17**
18	018	049	078	109	139	170	200	231	262	292	323	353	**18**
19	019	050	079	110	140	171	201	232	263	293	324	354	**19**
20	020	051	080	111	141	172	202	233	264	294	325	355	**20**
21	021	052	081	112	142	173	203	234	265	295	326	356	**21**
22	022	053	082	113	143	174	204	235	266	296	327	357	**22**
23	023	054	083	114	144	175	205	236	267	297	328	358	**23**
24	024	055	084	115	145	176	206	237	268	298	329	359	**24**
25	025	056	085	116	146	177	207	238	269	299	330	360	**25**
26	026	057	086	117	147	178	208	239	270	300	331	361	**26**
27	027	058	087	118	148	179	209	240	271	301	332	362	**27**
28	028	059	088	119	149	180	210	241	272	302	333	363	**28**
29	029	060	089	120	150	181	211	242	273	303	334	364	**29**
30	030		090	121	151	182	212	243	274	304	335	365	**30**
31	031		091		152		213	244		305		366	**31**
DAY	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**DAY**

(2016, 2020, 2024, 2028)

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

PROVIDER'S NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

HOME CARE 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	

PROVIDER'S NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

CLAIMS ERROR/PAYMENT CODE DESCRIPTIONS
NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801
TRENTON, NJ 08650-4801

DATE: M/DD/YY
REMITTANCE NO: 999999999
PROVIDER NO: 9999999

CODE	DESCRIPTION
0011	RECIPIENT NUMBER MISISNG INVALID
0013	INVALID BIRTHDATE
0026	CLAIM W/OUT ATTACHMENTS OVER 1 YEAR
0161	INVALID/MISSING HCPCS CODE
0301	RECIPIENT INELIG ON DATE OF SERVICE
0464	HIPAA CLAIM DENIED NO ATTACHMENT

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: 9999999

	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: 9999999 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

TO: PROVIDER'S NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

NEW JERSEY MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT – GAINWELL TECHNOLOGIES
P.O. BOX 4801

DATE: MM/DD/YY
PROVIDER NO: 9999999
PAGE: 1

INSURER DATA SUMMARY

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

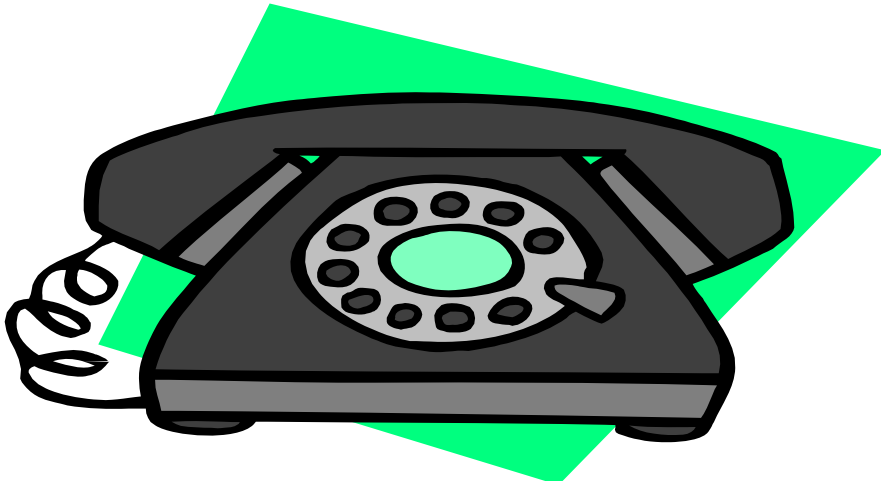
INSURED: DOE, JOHN
POLICY NO: XXXXXXXXXXXXX
POLICY HOLDER NAME: J BUCOLO

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: XXXXXXXXXXXXX
POLICY HOLDER NAME: JOHN DOE

DMAHS
THIRD PARTY LIABILITY (TPL)



PROVIDER'S USE ONLY

Call 609-826-4702 for:

- Assistance in Removing the Incorrect Commercial Insurance Information
- Assistance in Adding a new Commercial Insurance Payor
- Terminating Insurance - Informing of Commercial Insurance Termination Date
- Help with the Proper Payor/Carrier Code

Call 609-588-2944 for:

- To Correct Medicare information on the Beneficiary's File

MEDICARE BUY-IN

To update Medicare information on a Medicaid beneficiaries file, fax the following information to NJ Medicaid - Medicare Buy-In Unit at 609-588-2893.

1) Beneficiary Name
2) Beneficiary Social Security number and/or Medicaid ID number
3) Beneficiary date of birth
4) Reason for update (NJ Medicaid Eligibility Record shows Part A, Part A not active, person has Part B, NJ Medicaid Eligibility Record does not show Part B eligibility)
5) Requester's name, phone number and fax number

Every effort will be made to respond within 4 working days to each inquiry.

ALTERNATE METHOD OF NOTIFICATION:

1) Send your inquiry in writing to:

NJ Medicaid Buy-In Unit,
Mail Code #36,
PO Box 712,
Trenton, NJ 08625

2) Call the DMAHS Solutions Units at 1-800-356-1561 and request the BUY-IN Unit.

FORMS

AAA CLAIM CORRECTION FORM

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

REMIT DATE: **MM/DD/YY** PAGE: OF **1** of **2**

CONTROL NO.	**20240-1512-34**	LINE(S):	**01**	THRU:	**01**	DETAIL LINE NO:	**03**

02 04 00 20240 1512 34 01 01 01

RECIPIENT NAME / DATE OF BIRTH ON FILE: **DAVIS JOE 11/04/61**

ERROR CODES

0011

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
1234567	**01**	**DAVIS**	**J**	**11/04/61**	**11111111111**	**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**	**7654321**	**N**	**N**	**1234567890**	**0000000**	**0000000000**

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**	**4321**

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
07/01/24	**07/03/24**	**12**	**1**	**Z1600**			**G111**		**52**	**720.00**	

TOTAL CLAIM 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**	**07/25/24**			

MEDICARE DEDUCTIBLE F1	MEDICARE CHARGE ALLOW F2	MEDICARE BILLED AMOUNT F3	MEDICARE PAID AMOUNT F4	MEDICARE PAID DATE F5	

CLAIM CORRECTION FORM (CCF)

Since the hardcopy Remittance Advices will no longer be mailed, Providers must complete their CCF forms through the NJMMIS website. Please refer to Volume 13 No. 22 and Volume 21 No. 25.

ADJUSTMENTS

What are Adjustments?

- Specific changes to previously approved claims

How to adjust a Claim?

- Complete the MMIS Claim Adjustment Request form (FD-999)
- Attach a Corrected Paper Claim, only if the original claim was billed on paper (If electronic claim, write "EDI Claim" on the top of the FD-999 Form)
- Attach “any” required attachments with the Original Claim
- Attach a copy of the Remittance Advice (RA)
- Reference Vol. 3 No. 19, July 1993 - Claim Inquiries
- Circle or underline the Internal Control Number (ICN) of the claim that is to be adjusted
- Mail the FD-999 w/ the attachments to:

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

- Through the NJMMIS website

Other Important Information

- When adjusting a claim that has been previously adjusted, the ICN of the most current adjusted claim must be used.
- Proof of timely filing is not needed.
- **Previously denied claims must be resubmitted. Do not complete the FD-999 for resubmissions.**

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: 1 2 3 4 5 6 7

2. Provider Name:

PERSONAL HOME CARE INC.

3. Provider Address:

45 SOUTH 19TH STREET

WESTBORO, NJ **64080**
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 to 12**
Change charges to $420.00

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

6. Control Number (ICN): 2 0 2 4 5 1 1 1 1 1 1 0 2

7. Recipient Name: **DAVIS** **JOE**
Last First MI

8. Recipient HSP Number: 1 1 1 1 1 1 1 1 1 1 1 1

9. Remittance Advice Date: 0 9 1 4 2 4
M M D D Y Y

10. Provider Signature: *Original Signature* Date: MM/DD/YYYY

Send to: Gainwell Technologies, P.O. Box 4802, Trenton, NJ 08650

FISCAL AGENT USE ONLY

Date: _____ Reviewer: _____ Form Locator: ☐☐☐

FD 999 (01/21)

COMMON REASONS FOR ADJUSTMENTS

1) UNITS

Change units to 2.
Change charges to $50.00

NOTE: When adjusting units, be sure to adjust charges.

2) CHARGES

Change charges to $100.00.

3) DATES OF SERVICE

Change date of service to 050124.

4) PROCEDURE CODE

Change procedure code to S9122

.

VOIDS

What are Voids?

- Cancels previously approved claim

How to void a Claim?

- Complete the MMIS Claim Adjustment Request form (FD-999)
- Attach the Remittance Advice (RA) to the FD-999
- Reference Vol. 3 No. 19 - Claim Inquires
- Circle or underline the Internal Control Number (ICN) of the claim that is to be voided
- Mail the FD-999 w/ the RA to:

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

- Through the NJMMIS website

Common Reasons for Voids

- Using the Wrong Provider ID # (either Billing or Servicing)
- Using the Wrong Beneficiary ID #
- Service Not Provided
- Changing Medicaid payment from primary to secondary

Other Important Information

- **Do not submit a reimbursement check for the voided amount to Gainwell. If a check is included, the void will be delayed.**
- On the FD-999 form, print or type **VOID** in the description section. Resubmit the claim after the void appears on the RA.

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: 1 2 3 4 5 6 7

2. Provider Name:

PERSONAL HOME CARE INC.

3. Provider Address:

45 SOUTH 19TH STREET

WESTBORO, NJ **64080**
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: **Please void.**

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

6. Control Number (ICN): 2 0 2 4 5 1 1 1 1 1 1 0 2

7. Recipient Name: **LUTZ** **TIM**
Last First MI

8. Recipient HSP Number: 1 1 1 1 1 1 1 1 1 1 1 1

9. Remittance Advice Date: 0 9 1 4 2 4
M M D D Y Y

10. Provider Signature: *Original Signature* Date: MM/DD/YYYY

Send to: Gainwell Technologies, P.O. Box 4802, Trenton, NJ 08650

FISCAL AGENT USE ONLY

Date: _____ Reviewer: _____ Form Locator: ☐☐☐

FD 999 (01/21)

Adjustment/Void Processing Return to Provider Form

The enclosed forms are being returned to you by Gainwell Technologies, the Medicaid Fiscal Agent for the reasons indicated below. Please correct your adjustment or void form and resubmit. If you have any questions regarding this form, please contact us at 1-800-776-6334.

Reviewer ID _____ Date _____

_____ Provider # invalid or missing (ITEM 1)

_____ Control # (ICN) incorrect or missing (ITEM 6)

_____ Recipient # invalid or missing (ITEM 8)

_____ Remittance Advice Date missing (ITEM 9)

_____ Provider signature and/or date invalid or missing (ITEM 11)

_____ Description of the problem missing or can't be understood (ITEM 5)

_____ No remittance advice, original claim or attachments submitted

_____ Each claim line requires an FD999 submission

_____ Adjustment/Void form does not match the claim or remittance advice

_____ Denied claims cannot be adjusted or voided-resubmit a claim for payment

_____ The ICN# listed is for a denied claim. Resubmit FD999 using the paid claim ICN#

_____ Request is for a claim still on suspense- wait until claim is paid or denied

_____ Claim previously voided, can't be voided again

_____ Original claim was electronically submitted. A hardcopy claim is needed in order to adjust the record

_____ Other _____

_____

To avoid processing delays, do not use staples when submitting adjustments/voids

Please resubmit corrected forms to the Fiscal Agent using the appropriate PO Box

Note - This document cannot be used as proof of timely filing

Revised: 1/2021

gainwell

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 on 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	02/10/24	02/27/24	202435001123401
2. Jane Doe	321121230901	02/01/24		
3. John Doe	202013421520	01/30/24		202433611231402

INQUIRY

Claim was resubmitted on 05-02-24. Have not received claim payment.

REQUESTOR'S NAME Janet Doe (PLEASE PRINT) **DATE** 08/26/24

RESPONSE

A review indicates payment was made on 04/29/24. Please check.
your Remittance Advice.

PROVIDER INQUIRY
GAINWELL TECHNOLOGIES
PO BOX 4801
TRENTON, NJ 08650
FD-998 (01/21)

SIGNATURE JD **DATE** 9/3/24

NJMMIS FORM REQUEST

Provider Name:_____ Provider #_____

Mailing Street Address:_____
(Do Not Use PO Box)

City/State/Zip:_____

INSTRUCTIONS: Type or print your name, provider number, and full address above. Below, indicate the type and quantity of forms desired.

Quantity Needed	Form Number	Form Title
CLAIM FORMS		
_____	MC-6	Prescription Claim Form
_____	*MC-9	Request for Authorization and Payment--Optical Appliances
_____	MC-12	Transportation Claim Form
_____	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 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
_____	FD-411	Prior Authorization 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

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

Return Completed form to: **PUBLICATIONS COORDINATOR**
GAINWELL TECHNOLOGIES
P.O. BOX 4802
TRENTON, NJ 08650-4802

Revision Date: January 26, 2021

OTHER INFORMATION

TIMELY FILING

What is Timely Filing?

- Claims must be submitted within one (1) year from the Date of Service (DOS)
- Claims submitted more than one (1) year from the DOS must have **PROOF** that the claim was originally submitted within one (1) year from the DOS

Examples - Proof of Timely Filing

- The Remittance Advice (RA) having the Internal Control Number (ICN)
- Claim Correction Form (CCF) having the ICN
- Claim specific documentation from Gainwell Technologies or DMAHS

Exception: ***When Medicare pays the claim after one (1) year from the DOS, the provider has ninety (90) days from the Medicare paid date to submit the claim to Medicaid. The EOMB must indicate Medicare received the claim within the Medicaid original twelve (12) month timely filing period. The EOMB must be attached to the claim.***

Not Acceptable for Proof of Timely Filing

- A teleprocessing screen print acknowledgement.

How to submit a Claim with Proof of Timely Filing?

- Attach one (1) of the examples listed above of proof of timely filing with the claim
- Mail to the appropriate Gainwell Technologies P.O. Box (see reference page)

FAIR HEARING

- **After exhausting all other means available to get your claim paid, a Fair Hearing may be requested.**
- Review all denied claims to determine if the denial is due to any missing and/or incorrect information on the claim form or attachments.
- **Claims must be previously denied.**
- Reference Vol. 3 No. 19 - Claim Inquiries.

How to obtain a Fair Hearing?

A DENIAL must be appealed to Fair Hearing within 20 days of the Remittance Advice (RA) date.

1. Complete the Administrative Hearing Information form.
2. Attach the claim form with any supporting documentation to the Administrative Hearing Information form.
3. Mail the Administrative Hearing Information form, the claim(s), and supporting documentation to:

Gainwell Technologies
Attn: Fair Hearing
P.O. Box 4801
Trenton, NJ 08650-4801
(609) 588-6087

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

ADMINISTRATIVE HEARING INFORMATION FORM

(Please print clearly or type all applicable information)

Provider Information:

Name of Provider _____

Address and Telephone Number _____

Medicaid Provider Billing No. _____

Name of Attorney Representative _____

Address and Telephone Number _____

Recipient Information:

Recipient's Name _____

Recipient's HSP (Medicaid Case Number) _____

Recipient's Date of Birth _____

Claim Information:

Date(s) of Service _____

Claim Charge _____

Fiscal Agent Internal Control No. _____

Indicate Edit Code associated with denied claim and attach copy of Remittance Advice (RA) statement:

_____

_____

Explanation of Problem(s) Encountered (if more space Is needed please attach additional page):

_____

_____

_____

_____

_____

Request submitted by: _____ Date: _____

Contact Person (name and telephone number): _____

NOTE: PLEASE ATTACH RELEVANT DOCUMENTATION

RETURN TO: GAINWELL TECHNOLOGIES
FAIR HEARING UNIT
P.O. BOX 4801
TRENTON, NJ 08650-4801

FD-387 (02/21)

MANAGED CARE

Wellpoint New Jersey, Inc.
(Formerly Amerigroup New Jersey, Inc.)

Member Services: 1-800-600-4441 TTY# 1-800-855-2880
Provider Services: 1-800-454-3730

Horizon NJ Health

Member Services: 1-877-765-4325 TTY# 1-800-654-5505
Provider Services: 1-800-682-9091

United Healthcare Community Plan
(Formerly Americhoice of New Jersey, Inc.)

Member Services: 1-800-941-4647 TTY# 711
Provider Services: 1-888-362-3368

FIDELIS CARE
(Formerly Wellcare NJ)

Member Services: 1-888-453-2534 TTY# 1-877-247-6272
Provider Services: 1-866-687-8570

Aetna Better Health of NJ

Member Services: 1-855-232-3596 TTY# 711
Provider Services: 1-855-232-3596

MEDICAL ASSISTANCE CUSTOMER CENTERS

Michelle Pawelczak, Director
Office of Customer Service
Michelle.Pawelczak@dhs.nj.gov

MACC OFFICE	DIRECTOR & PHONE#	ADDRESS
(04) **CAMDEN** (03) BURLINGTON (08) GLOUCESTER (11) MERCER (17) SALEM (01) ATLANTIC (05) CAPE MAY (06) CUMBERLAND **Sophia.Proctor@dhs.nj.gov**	Sophia Proctor, Acting Director Phone: **(856) 209-0520** Fax: (856) 614-2575 John Sawicki, D.O.	One Port Center 2 Riverside Dr., Suite 300 Camden, NJ 08103-1018
(07) **ESSEX** (09) HUDSON **Carmen.morgan@dhs.nj.gov**	Carmen Morgan, Director Phone: **(862) 682-4430** Fax: (973) 642-6468 John Sawicki, D.O.	153 Halsey St. 4th Floor Newark, NJ 07102-2807
(13) **MONMOUTH** (10) HUNTERDON (12) MIDDLESEX (15) OCEAN (18) SOMERSET (20) UNION (14) **Beth.O'Neill@dhs.nj.gov**	Beth O'Neill, Director Phone: **(908) 430-0231** Fax: (732) 863-4450 John Sawicki, D.O.	100 Daniels Way 1st Floor Freehold, NJ 07728-2668
(16) **PASSAIC** (02) BERGEN (15) MORRIS (19) SUSSEX (21) WARREN (16) **Susan.M.Wojtasek@dhs.nj.gov**	Susan Wojtasek, Director Phone: **(862) 338-9890** Fax: (973) 684-8182 John Sawicki, D.O.	100 Hamilton Plaza 5th Floor Paterson, NJ 07505-2109

Rev. Apr. 2025

NEW JERSEY COUNTY SOCIAL SERVICE AGENCIES

ATLANTIC	1	**J. FORREST GILMORE, DEPT. HEAD** **KAREN B. ENOUS, DIRECTOR OF WELFARE**	ATLANTIC COUNTY DEPARTMENT OF FAMILY & COMMUNITY DEVELOPMENT 1333 ATLANTIC AVE.	
8:30-4:30		FAX 609-343-2374	ATLANTIC CITY, NJ 08401-8297	609-348-3001
BERGEN	2	**SCOTT MODERY, ACTING DIRECTOR**	BERGEN COUNTY BOARD OF SOCIAL SERVICES 218 ROUTE 17 NORTH	
8:00–4:30		FAX 201-368-8710	ROCHELLE PARK, NJ 07662-3300	201-368-4200
BURLINGTON	3	**VACANT, DIRECTOR**	BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD.	
8:00-4:30		FAX 609-261-0463	MOUNT HOLLY, NJ 08060-3335	609-261-1000
CAMDEN	4	**CHRISTINE HENTISZ, DIRECTOR**	CAMDEN COUNTY BOARD OF SOCIAL SERVICES 100 WOODCREST ROAD, SUITE 161	
8:30-4:30		FAX 856-225-5145	CHERRY HILL, NJ 08003	856-225-8800
CAPE MAY	5	**DONNA GROOME, DEPARTMENT HEAD**	CAPE MAY COUNTY DEPT. OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 3801 ROUTE 9 SOUTH – UNIT 4	
8:30-4:30		FAX 609-889-9332	RIO GRANDE, NJ 08242-1911	609-886-6200
CUMBERLAND	6	**CHERYL GOLDEN, DIRECTOR**	CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 275 NORTH DELSEA DR.	
8:30-4:30		FAX 856-692-7635	VINELAND, NJ 08360-3607	856-691-4600
ESSEX	7	**VACANT, DIRECTOR**	ESSEX COUNTY DEPARTMENT OF CITIZEN SERVICES DIVISION OF FAMILY ASSISTANCE & BENEFITS	
7:30-4:00 Limited services for emergency needs (3pm-5pm)		FAX 973-504-9316	320-321 UNIVERSITY AVE. - 2nd Fl. NEWARK, NJ 07102	973-395-8000
GLOUCESTER 8:30-3:30	8	**SHANE STEVENSON, DIRECTOR**	GLOUCESTER COUNTY DIVISION OF SOCIAL SERVICES 400 HOLLYDELL DR.	
8:00-5:00 (Tel hrs.)		FAX 856-582-6587	SEWELL, NJ 08080	856-582-9200
HUDSON	9	**MONICA YENG, DIVISION HEAD**	HUDSON COUNTY DEPARTMENT OF FAMILY SERVICES WELFARE DIVISION 257 CORNELISON AVENUE	
8:00-4:15		FAX 201-395-4624	JERSEY CITY, NJ 07302	201-420-3000
HUNTERDON	10	**LISA PIAZZA, DIVISION HEAD**	HUNTERDON COUNTY DEPT OF HUMAN SERVICES DIVISION OF SOCIAL SERVICES 6 GAUNTT PLACE P.O. BOX 2900	
8:30-4:30		FAX 908-806-4588	FLEMINGTON, NJ 08822-2900	908-788-1300
MERCER	11	**JEFFREY MASCOLL, DIRECTOR**	MERCER COUNTY BOARD OF SOCIAL SERVICES 200 WOOLVERTON ST., P.O. BOX 1450	
8:30-4:30		FAX 609-394-6638	TRENTON, NJ 08650-2099	609-989-4320
MIDDLESEX	12	**DARA HARKAY, DIRECTOR** FAX 732-745-4558	MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES 181 HOW LANE, P.O. BOX 509	
8:30-4:15		WFNJ FAX 732-745-4555	NEW BRUNSWICK, NJ 08903	732-745-3500
MONMOUTH	13	**CATHERINE LORD, DIRECTOR** ✓ FAX 732-431-6017	MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES 3000 KOZLOSKI RD., P.O. BOX 3000	
8:30-4:30 (Freehold Office)		WFNJ FAX 732-431-6267	FREEHOLD, NJ 07728	732-431-6000
MORRIS	14	**GARY DENAMEN, DIRECTOR**	MORRIS COUNTY OFFICE OF TEMPORARY ASSISTANCE 340 W. HANOVER (MORRIS TOWNSHIP), P.O. BOX 900	
8:30-4:30		FAX 973-829-8531	MORRISTOWN, NJ 07963-0900	973-326-7800
OCEAN	15	**MEREDITH SHEEHAN, DIRECTOR**	OCEAN COUNTY BOARD OF SOCIAL SERVICES 1027 HOOPER AVE., P.O. BOX 547	
8:30-4:30		FAX 732 244-8075	TOMS RIVER, NJ 08754-0547	732-349-1500
PASSAIC	16	**TALISA COLEMAN, DIRECTOR**	PASSAIC COUNTY BOARD OF SOCIAL SERVICES 80 HAMILTON ST.	
7:30-4:00		FAX 973-881-3232	PATERSON, NJ 07505-2060	973-881-0100

SALEM	17	**RICH STUART, DIRECTOR**	SALEM COUNTY BOARD OF SOCIAL SERVICES 147 S. VIRGINIA AVE.	
8:00-4:00		FAX 856-299-3245	PENNS GROVE, NJ 08069-1797	856-299-7200
SOMERSET	18	**MARION COOPER, ESQ., DIRECTOR**	SOMERSET COUNTY BOARD OF SOCIAL SERVICES 73 E. HIGH ST., P.O. BOX 936	
8:30-4:30		FAX 908-707-1941	SOMERVILLE, NJ 08876-0936	908-526-8800
SUSSEX	19	**JOAN BRUSEO, DIVISION DIRECTOR**	SUSSEX COUNTY DIVISION OF SOCIAL SERVICES 83 SPRING ST., STE. 203. P. O. BOX 218	
8:30-4:30		FAX 973-383-3627	NEWTON, NJ 07860	973-383-3600
UNION	20	**DEBBIE-ANN ANDERSON, DIRECTOR**	UNION COUNTY DIVISION OF SOCIAL SERVICES 342 WESTMINSTER AVE.	
8:00-4:00		WFNJ FAX 908-965-2752	ELIZABETH, NJ 07208-3290	908-965-2700
WARREN	21	**LAUREN BURD, DIVISION DIRECTOR**	WARREN COUNTY DIVISION OF TEMPORARY ASSISTANCE AND SOCIAL SERVICES 1 SHOTWELL DRIVE	
8:30-4:30		FAX: 908-475-1533	BELVIDERE, NJ 07823	908-475-6301

(Revised 4/2024) ✓ Denotes Change (Changes should be reported to 609-588-2417)

P.O. BOX NUMBERS

MAIL TYPE	P.O. BOX #
Fair Hearing/Good Faith/ Written Inquiries	4801
Adjustments/Voids/All Claim Forms	4802
HBID	4803
Provider Enrollment	4804
Long Term Care (LTC) - Turn Around Document (TAD)	4805
UB-04 Hospital Inpatient/Outpatient & Home Health Agency Services	4802
Pharmacy	4802
CMS-1500 (formerly HCFA-1500)	4802
Claim Correction Form (CCF)/ Medicare/Medicaid Crossovers	4802
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	4802
Dental	4802
Vision	4802
Transportation	4802
Computer Operations (EDI)	4814
NJMMIS Request Form (Publications)	4802

Use the appropriate P.O. Box when mailing claims to Gainwell Technologies.

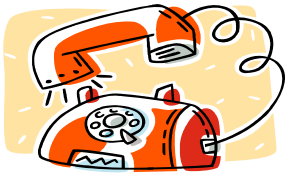
Example:

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

The Zip Code should follow the appropriate P.O. Box #.

Example: 08650-4802 is for all claim forms

gainwell



_____
Write your 7-digit NJ Medicaid Provider ID #

_____
Write your Submitter #

PHONE NUMBERS

Department	Phone #	Reason
Provider Services Call Center	1-800-776-6334	Monday thru Friday – 8 AM to 5 PM ➢ Claims Information ➢ Eligibility **ONLY** for beneficiaries > 1 year from DOS ➢ To Request Billing Training
Website: www.njmmis.com		➢ Adjustments/Voids ➢ CCFs ➢ C3 Clear Claim Correction ➢ Direct Data Entry (DDE) ➢ e-MEVS ➢ Edit Code Descriptions ➢ Forms, Newsletters ➢ Provider Directory, Manuals, & Guides ➢ Remittance Advice
Recipient Eligibility Verification System (REVS)	1-800-676-6562	24 hours a day, 7 days a week ➢ Remittance Advice (RA) Information
Second Opinion	1-800-676-6562	Monday thru Friday – 8 AM to 5 PM ➢ For Beneficiaries & Providers requesting Information about Procedures requiring a Second Opinion (refer to Newsletter Vol. # 2 No. 22.
Provider Enrollment	609-588-6036	Monday thru Friday – 8 AM to 5 PM ➢ Applications ➢ Request Submitter ID ➢ Obtain a NJ Medicaid Provider ID # ➢ To Change an Address ➢ Sign up for Automatic Deposit
Electronic Data Interchange (EDI)	609-588-6051	➢ Technical questions on confirmations & rejections on electronic files
Electronic Data Interchange (EDI)	609-584-8268	➢ Telecommunications
MEP	877-888-2939	➢ Pharmacy Prior Authorizations

Gainwell Technologies at a Glance

This is a quick reference to Gainwell Technologies phone numbers. Keep it in a convenient location so you can reference the correct phone number to call for assistance.

PROVIDER SERVICES CALL CENTER 1-800-776-6334

To process your call, Providers MUST have their NJ 7-digit Medicaid Provider ID# to gain access to the Call Center. If you do not have it available, our representatives will not be able to assist you. This is for security purposes and policy.

Common Questions

1. ***Why did my claim(s) deny? To answer this question, the provider must have the following:***

    - *Internal Control # (ICN) or the Beneficiary ID#*
    - *Date of Service (DOS)*

2. ***My Remittance Advice (RA) was lost or never received? How do I receive another one?***

    - *Effective January 2012 Providers must download their Remittance Advice through the NJMMIS website.*

3. ***Has Gainwell Technologies received my claim? To answer this question, the provider must have the following:***

    - *Beneficiary ID#*
    - *DOS*

4. ***We are calling to check eligibility? This question will only be answered for beneficiaries that are > than one (1) year from the DOS.***

    - ***If you are calling for eligibility by SS #, ID # or for check amount, you** MUST call REVS at 1-800-676-6562. Gainwell is unable to check eligibility for beneficiaries less than one year from date of service.*

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM (REVS) 1-800-676-6562

To process your call, Providers **MUST** enter their NJ 7-digit Medicaid Provider ID# to gain access to the system. If you do not have it available do not contact the Provider Services Call Center; they will not be able to assist you without a Provider ID#.

Common Reasons

1. ***Beneficiary Eligibility***

2. ***Weekly Check Amount***

Dial 1	***Beneficiary Eligibility***
Dial 3	***Second Opinion***
Dial 4	***RA Information***
Dial 9	***End Call***

NJMMIS WEBSITE
www.njmmis.com

Visit the Gainwell website to access Medicaid Information & Publications. This is another option instead of contacting the Provider Services Call Center, Provider Enrollment or EDI.

- Order Provider Manuals & Forms
- Provider Services e-mail
- View, Download and/or Print Billing Supplements/Training Packets, Newsletter, Alerts, HIPAA Companion Guide, NCPDP Companion Guide, HIPAA Approved Vendor List, MEVS/POS Installation Guides
- Search & View Edit Codes with Explanations/Descriptions
- Submit a Provider Request
- FAQ
- Link to DMAHS or DHSS websites
- View and/or request a NJ Medicaid Provider Directory
- Physician Administered Drugs (UOM)
- Long Term Care (LTC) Forms
- Procedure Codes and Rate Information

To gain access to our Secure Site for additional features, you need to register. Once you have registered, you will obtain a Login and Password. You will be able to access:

- CCF (Claim Correction Form)
- Submit Judge Run Requests
- View & Download Judge Run Reports
- Submit Census Data (LTC Providers Only)
- View FFS & Charity Care RA Reports
- Access an Enhanced Provider Directory
- View RA, last 12 weeks
- eMEVS - Electronic Medicaid Eligibility Verification System
- Submit Direct Data Entry (DDE) claim
- Submit Adjustments/Voids