

STATE OF NEW JERSEY



Department of Human Services
Division of Medical Assistance
and Health Services

NEW JERSEY
MEDICAID MANAGEMENT
INFORMATION SYSTEM
(NJMMIS)

**PHYSICIAN
TRAINING**

APRIL 2025

gainwell

AGENDA

INTRODUCTION TO GAINWELL TECHNOLOGIES

FORMS OF COMMUNICATION

Newsletters
Medicaid Alerts
Newsletter Vol 23 No. 20

BENEFICIARY ELIGIBILITY

Medicaid Identification Number
Health Benefits Identification Card

CLAIM COMPLETION

1500
Place of Service Codes
Billing Other Insurance
Values for Form Locator 24-H
Check Points
Perm Audit Reminders
HIPAA Attachment Cover Sheet
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)
McKesson Claim Check
DMAHS Third Party Liability (TPL)
Medicare Buy-In

FORMS

Claim Correction Form (CCF)
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

AGENDA

OTHER INFORMATION

Timely Filing

Fair Hearing

Managed Care Directory

MACC Directory

New Jersey County Social Service Agencies

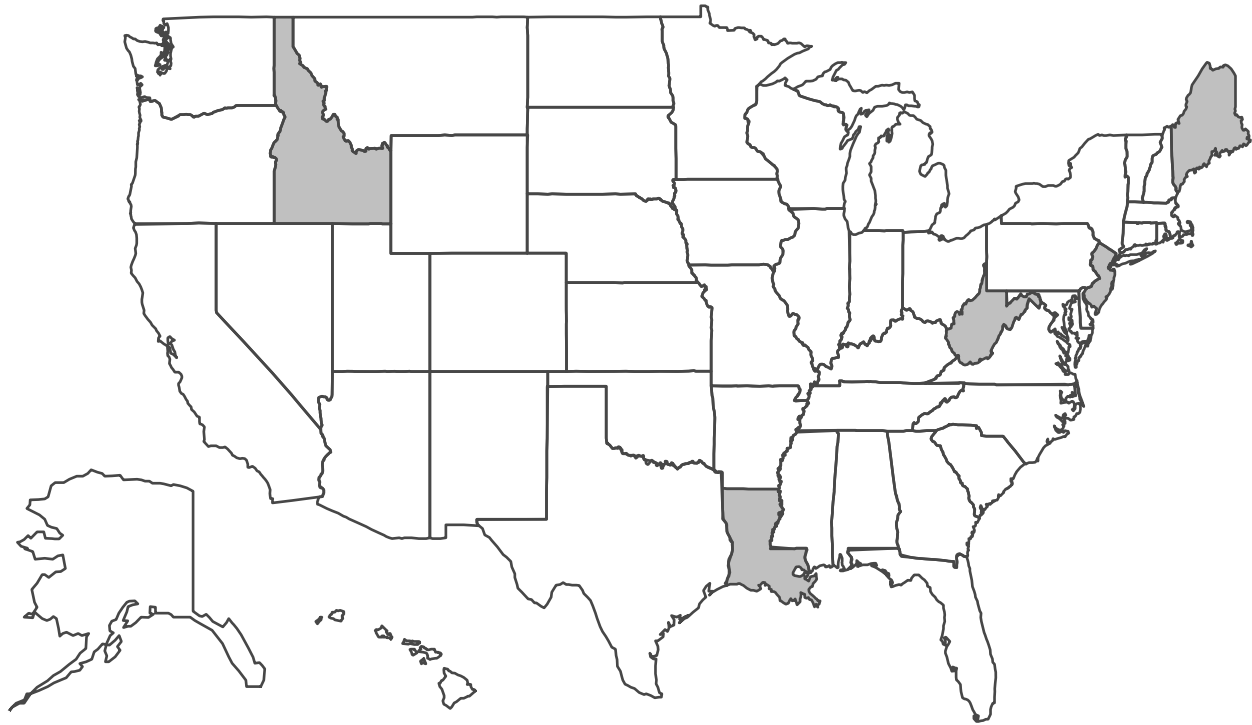
P.O. Box Numbers

Phone Numbers

Gainwell Technologies at a Glance

NJMMIS Website

gwinwell



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.njmms.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 <i>(inclusive of physician, certified nurse practitioner/clinical nurse specialists)</i>	✓	✓	✓	✓	✓
Specialist Visits	✓	✓	✓	✓	✓
Outpatient Surgery	✓	✓	✓	✓	✓
Chiropractic Services <i>(limited to spinal manipulation)</i>	✓	✓	✓	Not Covered	✓
Chemotherapy	✓	✓	✓	✓	✓
Radiation Therapy	✓	✓	✓	✓	✓
Anesthesia by Local Infiltration	✓	✓	✓	✓	✓
Free-Standing Ambulatory Clinic Services/ End Stage Renal Dialysis Services	✓	✓	✓	✓	✓
Access to Clinical Trials <i>(limited to coverage of hospital costs for clinical trials)</i>	✓	✓	✓	✓	✓
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 <i>(limitations apply)</i>	✓	✓	✓	✓	✓

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	✓	✓	✓	✓ <i>(Limited to non-nursing facility based)</i>	✓
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	✓	✓	✓	✓ <i>(limited to detoxification for alcoholism)</i>	✓
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 (<i>prior authorization required; 25 hour per week limit</i>)	✓	✓	✓	✓	✓
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 (<i>prior authorization required for psychotherapy beyond financial threshold of \$900</i>)	✓	✓	✓	✓	✓

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 to 133% 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

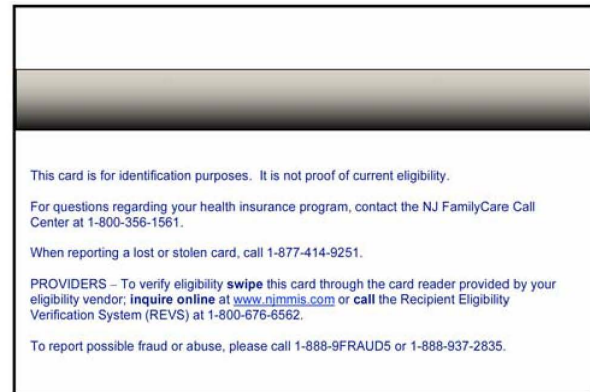
BENEFICIARY MEDICAID NUMBER

2		0																	
COUNTY				7		0													
				PROGRAM		9		9		9		9		9		9		0 1	
						CASE #										PERSON #			
01	Atlantic																	01	Adult
02	Bergen																	05	Unborn Child (Medicaid
03	Burlington																		Only, Pregnant Women)
04	Camden																	10	Essential Person
05	Cape May																	20-39	Children Under 21
06	Cumberland	10	Aged-SSI Related															40-47	Medicaid Special-Sibling
07	Essex	15	Aged-Medically Needy																within One Family Unit
08	Gloucester	20	Disabled-SSI Related															48	Medicaid Special-
09	Hudson	25	Disabled-Medically Needy																Second Individual
10	Hunterdon	30	Aid to Families with																Sibling with 49 in a
11	Mercer		Dependent Children																Marital Relationship
12	Middlesex	35	Medically Needy Children and Pregnant Women															49	Medicaid Special-Single
13	Monmouth	50	Blind-SSI Related																Individual
14	Morris	55	Blind-Medical Needy																
15	Ocean	60	Department of Children & Families (DCF)																
16	Passaic	70	Medical Assistance for Aged - State Program - MAA																
17	Salem	80	Juvenile Services																
18	Somerset																		
19	Sussex																		
20	Union																		
21	Warren																		
23	FamilyCare																		
24	FamilyCare																		
25	Presumptively Eligible/FamilyCare																		
35	CSOC (formerly CSOC/PFC, CBHS)																		

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



- 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 Passw ord
 - Provider Directory
 - Provider Enrollment Application
 - Provider Registration
- Information
 - Approved Vendor List
 - Billing Supplements / Training Packets
 - Recent New sletters
 - Edit Codes
 - FAQ
 - Forms & Documents
 - Physician Administered Drugs (UOM)
 - Rate and Code Information
 - New sletters & Alerts
 - NJ State MAC
- Secured Options
 - Change Passw ord
 - 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/yyyy)

Card Control Number:

State Bureau Identification (SBI):

Reset Page

Submit Request

Print Result

Physician Administered Drugs (UOM)
Rate and Code Information
New Letters & 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

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 SBT:		
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 NJMIS.COM FOR NEWSLETTERS VOL.23 NO.20, VOL.25 NO.12: COVERED FOR SUBSTANCE USE DISORDER TREATMENT. REFER TO NJMIS.COM FOR NEWSLETTER VOL.26 NO.06	
Eligible Services:	1-Medical Care	33-Chiropractic
	45-Hospice	47-Hospital
	50-Outpatient Hospital	88-Emergency Services
	98-Physician Visits	AL-Vision
	UC-Urgent Care	35-Dental Care
		48-Inpatient Hospital
		88-Pharmacy
		MH-Mental Health
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 BENEFICIARY HAS COVERAGE WITH ANOTHER INSURER. CONTACT THE INSURER FOR DETAILS ON COVERAGE OR BENEFITS	
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 BENEFICIARY HAS COVERAGE WITH ANOTHER INSURER. CONTACT THE INSURER FOR DETAILS ON COVERAGE OR BENEFITS	

CLAIM COMPLETION



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) 123456789001									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BROWN JANE										3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☒ MM DD YY M F									
5. PATIENT'S ADDRESS (No., Street) 454 MAIN STREET										6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐									
CITY ANYTOWN										CITY									
STATE NJ										STATE									
ZIP CODE 12345										ZIP CODE									
TELEPHONE (Include Area Code) (609) 555-5555										TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) ☐									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? ☐ YES ☒ NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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: 06/01/24										11. INSURED'S POLICY GROUP OR FECA NUMBER									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
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) A. D530 B. C. ICD Ind. 0 D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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. EXTEND FAMILY PLAN I. ID. QUAL J. RENDERING PROVIDER ID #																			
1 06 01 24 06 01 24 11 99213 A 10000 1 G2 7654321 0123456789																			
2																			
3																			
4																			
5																			
6																			
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 \$ 10000									
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.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # MID JERSEY FAMILY 999 OAK LEAF LANE ANYTOWN, NJ 123456 (609) 555-5555																			
SIGNED I M A BILLER DATE 06/15/24										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

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

2024076100060

☐ 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) 123456789001	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BROWN JANE		3. PATIENT'S BIRTH DATE SEX MM DD YY MM DD YYYY M ☐ F ☐	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) ☐ c. OTHER ACCIDENT? ☐ YES ☒ NO 10d. CLAIM CODES (Designated by NUCC)	
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: _____		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY M ☐ F ☐ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		15. OTHER DATE QUAL. MM DD YY 16. DATES OF PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
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) A. D530 B. C. ICD Ind. 0 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 10 01 24 10 01 24		B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HPCS MODIFIER 99213	
E. DIAGNOSIS POINTER A		F. \$ CHARGES 10000	
G. DAYS OR UNITS 1		H. BRST PWAY PLAN G2	
I. ID. QUAL. 7654321		J. RENDERING PROVIDER ID # 0123456789	
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 \$ 10000	
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.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()			
SIGNED I M A BILLER DATE 10/15/24		a. NPI b. 1234567890 c. 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
1 – Doctor's Office
2 – Patient's Home
3 – Inpatient Hospital

4 – Boarding Home

5 – Skilled Nursing Home

6 – Independent Laboratory
7 – Outpatient Hospital

8 – Clinic

9 – Other

23 – Emergency Room – Hospital
11 – Office
12 – Home
21 – Inpatient Hospital
51 – Inpatient Psychiatric Facility
61 – Comprehensive Inpatient Rehabilitation Facility
14 – Group Home
33 – Custodial Care Facility
31 – Skilled Nursing Facility
32 – Nursing Facility
54 – Intermediate Care Facility/Mentally Retarded
81 – Independent Laboratory
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
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
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**

VALUES FOR FORM LOCATOR 24-H

CMS-1500

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



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.

PERM AUDIT – Payment Error Rate Measurement REMINDER

What is PERM Audit?: PERM Audit is when CMS measures the accuracy of Medicaid and CHIP payments made by States for services rendered to recipients through the PERM program. CMS uses contractors to measure improper payments. Provider's interactions in this process will be primarily with the CMS contractor who will collect medical policies from the State and medical records from you as a provider.

Medical Records are needed to support claims billed. CMS contractor will contact you(provider) for medical records. It is important that cooperation with submitting all requested documentation in timely manner. Failure to do so may result in a recovery of payment and further action. For further details see Medicaid Newsletter Vol. 31 No. 20.

1. NJ Medicaid ensures compliance with the CMS National Correct Coding Initiative (NCCI). NCCI edits are applied to Medicaid services billed by providers. NCCI edits prevent inappropriate payment of services that should not be reported together.
2. Anesthesiologists.....Medicaid requests for Anesthesia Record when provider billed more than 40 units of anesthesia. Please inform providers to submit the Anesthesia Record upon request. DMAHS receives pended anesthesia claims; claims get a denial code of 0261 to inform providers to submit the requested record.
3. Laboratory.....State may request for documentation of medical necessity if service code claim exceeds payment threshold (\$1000)
4. Please include the correct medical records to justify the denied claim for Fair Hearing cases, denied claims and pended claims. State receives several pages of documents but the needed medical documentation overrides the denial is not included sometimes. This is applicable specifically to Emergency Department E&M claims (99281, 99282, 99283, 99284, 99285 with Modifier 25). There should be a separate identifiable significant Evaluation and Management (E/M) that is above and beyond the usual procedure performed like minor surgical procedure for both E&M and minor procedure claims get paid.
5. Please make sure the use of Modifier 25 is appropriate for E/M service code claims like 99211, 99212, 99213, 99214 and 99215when billed with minor procedures codes as 100060, 10061, 12001, etc. There should be a separate identifiable significant E/M that is above and beyond the minor procedure performed.



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

HIPAA Attachment Cover Sheet

1. NJ Medicaid Provider ID

--	--	--	--	--	--	--	--

2. Current Date

M	M	D	D	C	C	Y	Y

3. Provider Name and Address:

City

State

Zip Code

4. Control Number (ICN)

Beginning ICN

2	0																
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Ending ICN

2	0																
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

A range of ICN control numbers may only be entered for claims containing consecutive lines for the Attachment Codes below indicated with an *. This option is not available for claims that require manual pricing.

5. Medicaid Beneficiary ID

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

6. Date of Service

										-							
M	M	D	D	C	C	Y	Y			M	M	D	D	C	C	Y	Y

7. Patient Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

8. Attachment Code

- * ☐ 01 – Third Party Liability (TPL)/Explanation of Benefits (EOB) or Denial Letter Other than Medicare
- * ☐ 04 – Hysterectomy Receipt of Information form (FD-189)
- * ☐ 05 – Sterilization Consent Form (7473-M-ED)
- * ☐ 06 – Medical Records
- * ☐ 07 – Medical Second Opinion Referral Form (FD-263)
- * ☐ 08 – Miscellaneous
 - Remittance Advice
 - Judge Runs
 - Invoice
 - Compound Drug Lists
 - Prescriptions

- * ☐ 09 – Transportation Medical Certification Stmt. (CITE-20)
- * ☐ 10 – Out of State Prior Authorization (LD25)
- * ☐ 11 – Medicalv Needv Transmittal Form (FD-311)
- * ☐ 12 – Lock-in (SSP-14)
- * ☐ 13 – Certification of Treatment of Emergency (FD-80)
- * ☐ 17 – Generic Testing Supporting Information Form (FD-431)

To the best of my knowledge, the above is true, accurate, complete, and the requested services are medically indicated and necessary to the health of the patient. **Note:** Authorization does not guarantee payment. Payment is subject to patient's eligibility. Be sure the patient's eligibility is current before rendering service. Please refer to the HIPAA Companion Guide on the NJMMIS website at www.njmmis.com for detailed instructions.

Submit this sheet with your attachments to:

Gainwell Technologies
Attn: HIPAA Attachments
Post Office Box 4752
Trenton, New Jersey 08650-4752

Version 5010

September 2023

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

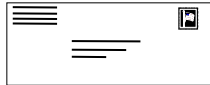
CLAIMS PROCESSING FLOW

ADJUDICATED CLAIMS WILL APPEAR THE FOLLOWING WEEK

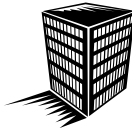
Paper Claims Submission 24 DAYS



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.



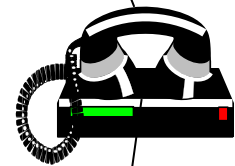
The claim is received by our claims processing system.

VS

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



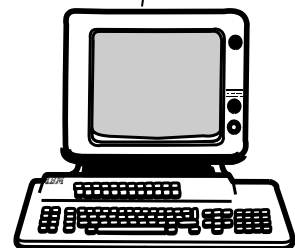
The claim is entered at your office and transmitted directly to Gainwell Technologies.



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

**Receipt
Year**

154

**Receipt
Julian Date**

01

**Roll
Number**

1234

**Sequence
Number**

01

**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

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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

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

PAGE: 2

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 (5806)	J)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES	40.00	13.30	.00	13.30	9999999999999
APPROVED ORIGINAL CLAIM TOTALS						1 CLAIM	379.00	144.72	.00	144.72
ADJUSTED CLAIMS										
111111111111 LUCIANO (0580047132004138)/PHYS	E)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES	20.00	11.20	.00	11.20	9999999999999
111111111111 LUCIANO (0580047132004138)/PHYS	E)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES	10.00	10.00	.00	10.00	9999999999999
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 (0580053112004152)/PHYS	B)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES	20.00	11.20	.00	11.20	9999999999999
VOIDED CLAIM TOTALS						1 CLAIM	.00	429.50	.00	429.50
DENIED CLAIMS										
111111111111 CORDON (1234581)	D)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES ERROR CODES: 0301	50.00	.00	.00	.00	9999999999999
DENIED CLAIM TOTALS										
CLAIMS IN PROCESS										
111111111111 OWENS (7489)	P)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES ERROR CODES: 0026 0464	40.00	.00	.00	.00	9999999999999
CLAIMS IN PROCESS TOTALS						1 CLAIM	127.00	.00	.00	.00
CLAIMS IN PROCESS - CCF										
111111111111 SMITH (4321)	A)/PHYS	MM/DD/YY NO: 7777777	MM/DD/YY	1	99999 SERVICES	40.00	.00	.00	.00	9999999999999
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: MM/DD/YY
REMITTANCE NO: 999999999
PROVIDER NO: 9999999

PAGE: 5

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**

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

PAGE: 2

	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

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: 999999999999

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: 999999999999

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

McKesson ClaimCheck® Solution

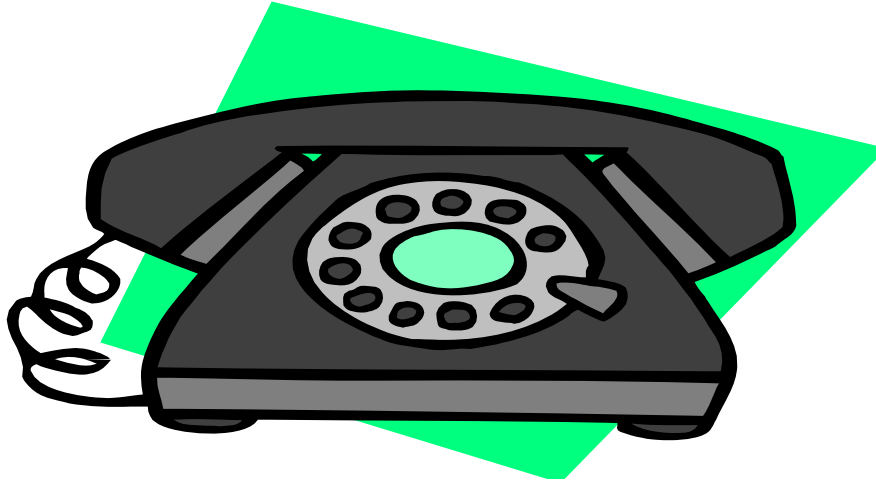
In May 2007, Gainwell Technologies, in conjunction with the State of NJ, implemented the use of ClaimCheck® to enhance the quality of claims payments to the NJFC/Medicaid fee-for-service (FFS) providers.

ClaimCheck® is a claims auditing software system that automatically audits and adjusts professional billing errors and detects common code manipulations to avoid claim overpayments.

Edits specific to Claim Check will be in the range of 1800-1899. **Please note:** Clear Claim Connection does not audit for the edit 1897, “Procedure not expected for diagnosis”, therefore, providers will not see this denial when checking procedure codes using the Clear Claim Connection (C3) tool on our website. You may access Clear Claim Connection (C3) by logging on to the www.njmmis.com website, under the “Secured Options” section.

Reference Newsletters: Volume 17, No. 12 and Volume 21 No. 02 for more information on the McKesson ClaimCheck® Solution.

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

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.	20244-1111-11	LINE(S):	03	THRU:	03	DETAIL LINE NO:	03			0011	ERROR CODES
01 04 00 20244 1111 11 03 03 03										FOR A DESCRIPTION OF THE ERROR CODES SEE REVERSE SIDE OF THIS PAGE	
RECIPIENT NAME / DATE OF BIRTH ON FILE: DOE JANE 06/11/44											

BILLING PROVIDER		MULT		NAME ON CLAIM				BIRTH DATE		MEDICAID ID		OTHER		CARRIER CODES				
A1		A2	ADDR	A3	LAST	A4	FIRST	A5		A6	NUMBER	A7	INS	A8	A9	A10		
1234567		01		DOE				J		06/11/64		11111111111		N				

INDICATORS				REFERRING PROVIDER				INDICATORS				PRIOR AUTHORIZATION				SHCF		GSHP AUTHORIZATION	
B1	EMPLOY	B2	ACCID	B3		B4	LAB	B5	EPSDT	B6		B7		B8		B9			
N		N		7654321				N		N		1234567890				0000000		0000000000	

VISION EXAM DATE				(OPT) DISPENSED				(OPT) PRESCRIBING				TOOTH				FAMILY		PATIENT	
C1	PREV	C2	CURR	C3		C4		C5		C6		C7		C8		C9			
N/A		N/A		N/A				N/A				N/A		N/A		123456788			

DATE OF SERVICE				POS/		TOS/		PROCEDURE				DIAGNOSIS				DAYS		LINE		SERVICING			
D1	FROM	D2	THRU	D3	ORIG	D4	DEST	D5	CODE	D6	MOD	D7	MOD	D8	CODE	D9	CODE	D10	UNIT	D11	CHARGE	D12	PROVIDER
01/23/24		01/23/24		1		1		93000		ZP				D530				1		25.00		1234567	

TOTAL CLAIM				PAID BY OTHER				DATE				MEDICARE PROVIDER				MEDICARE CLAIM NUMBER				MEDICARE ID (MBI)			
E1		E2		E3		E4		E5		E6		E7		E8		E9		E10		E11		E12	
25.00				0.00				01/25/24															

MEDICARE				MEDICARE				MEDICARE				MEDICARE				MEDICARE							
F1		F2		F3		F4		F5		F6		F7		F8		F9		F10		F11		F12	
DEDUCTIBLE				CHARGE ALLOW				AMOUNT				AMOUNT				PAID DATE							

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
---	---	---	---	---	---	---

4. Reason (Circle One)

☐	☐	0	4	Claim Correction*
☐	☐	0	5	Void - Wrong Provider
☐	☐	0	6	Void - Wrong Recipient
☐	☐	0	7	Void - Service Not Provided
☐	☐	3	7	Insurance Recovery
☐	☐	6	1	LTC Patient Liability Change
☐	☐	6	2	LTC Leave of Absence Correction
☐	☐			STATE OFFICE USE ONLY ☐
☐	☐			☐

2. Provider Name:

New Jersey Family Practice

3. Provider Address:

999 Oak Leaf Lane

Anytown, NJ

City, State

08111

Zip Code

*Explain Below in Item 5

5. Description of the Problem:

Change units to 2

Change charges to \$50.00

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:

BROWN

JANE

Last

First

MI

8. Recipient HSP
Number:

1	1	1	1	1	1	1	1	1	1	1	1
---	---	---	---	---	---	---	---	---	---	---	---

9. Remittance Advice Date:

0	3	1	6	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:

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FD 999 (01/21)

COMMON REASONS FOR ADJUSTMENTS

1) UNITS

Change units to 2.

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 99215.

5) PROCEDURE CODE MODIFIER

Change modifier to 26.

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:

Mid Jersey Family Practice

3. Provider Address:

999 Oak Leaf Lane

Anytown, NJ

City, State

08111

Zip Code

4. Reason (Circle One)

☐	☐	0	4	Claim Correction*
☐	☐	0	5	Void - Wrong Provider
☒	☐	0	6	Void - Wrong Recipient
☐	☐	0	7	Void - Service Not Provided
☐	☐	3	7	Insurance Recovery
☐	☐	6	1	LTC Patient Liability Change
☐	☐	6	2	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: BROWN JANE MI
Last First

8. Recipient HSP Number:

1	1	1	1	1	1	1	1	1	1	1	1
---	---	---	---	---	---	---	---	---	---	---	---

9. Remittance Advice Date:

0	3	1	6	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:

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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



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

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

MANAGED CARE

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

Member Services: 1-800-600-4441
Provider Services: 1-800-454-3730

TTY# 1-800-855-2880

Horizon NJ Health

Member Services: 1-877-765-4325
Provider Services: 1-800-682-9091

TTY# 1-800-654-5505

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

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

TTY# 711

FIDELIS CARE (Formerly Wellcare NJ)

Member Services: 1-888-453-2534
Provider Services: 1-866-687-8570

TTY# 1-877-247-6272

Aetna Better Health of NJ

Member Services: 1-855-232-3596
Provider Services: 1-855-232-3596

TTY# 711

MEDICAL ASSISTANCE CUSTOMER CENTERS

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

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

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

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

(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



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