PROVIDER CLAIMS MANUAL

Revised April 2022

Michigan
Provider Manual
1 Campus Martius, Suite 700
Detroit, MI 48226
888-437-0606

Dear Meridian Provider,

Meridian would like to welcome you to the Meridian network of providers! Our Provider Claims Manual was designed to assist you with understanding policies, procedures, and other protocols related to Michigan Medicaid, as well as a reference tool for you and your staff.

The Provider Claims Manual is a dynamic tool and will evolve with Meridian. Minor updates and revisions will be communicated to you via *Provider Bulletins*, which serve to replace information found within this Provider Claims Manual. Major updates and revisions will be communicated to you via a revised edition of the Provider Manual, which will be provided to you. The Provider Claims Manual will be reviewed and updated annually. The revised edition will replace older versions of the Provider Claims Manual.

The latest Provider Manual is always available on our website at **https://www.mimeridian.com/providers**

Please contact your local Provider Network Development Representative or our Provider Services department at **888-437-0606**with any questions or concerns. If you are not yet a contracted provider with Meridian, visit our website at **https://www.mimeridian.com** and click “Join Our Network”.

Thank you for being part of the Meridian network!

Meridian

Table of Contents

Section 1: Billing and Claims Payment

Overview

Meridian's Claims department is organized to precisely process claims in a timely manner. Meridian has established a toll-free telephone number for providers to access a representative should you need to contact the plan for claims related questions.

MI Provider Number: 888-437-0606

Claims Billing Requirement

Sample forms for the CMS 1500 and the UB-04 forms are provided at the back of the manual[1].
In order to receive reimbursement in a timely manner, please ensure each claim:

- Uses the data elements of UB-04 (UB-04 Version 050) or CMS 1500 as appropriate **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf**
- Is submitted within 365 days of the date the service was performed
- Identifies the patient (Member ID assigned by Meridian, address, and date of birth)
- Identifies the plan (plan name and/or member ID number)
- Lists the date (*mm/dd/yyyy*) and place of service
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Meridian
- Includes additional documentation based upon services rendered as reasonably required by Meridian Medical Policies:
  - https://mimeridian.com/providers/resources/medical-policies.html
- Is certified by provider that claim:
  - Is true, accurate, prepared with the knowledge and consent of provider ○ Does not contain untrue, misleading, or deceptive information
  - Identifies each attending, referring, or prescribing provider, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
- Is a claim for which the provider has verified the member's eligibility and enrollment in Meridian before the claim was submitted

[1] See *Appendix I* for example forms

- Is not a duplicate of a claim submitted within 45 days of the previous submission
- Is submitted in compliance with all of Meridian's prior authorization and claims submission guidelines and procedures
- Is a claim for which provider has exhausted all known other insurance resources for the Medicaid line of business (Medicaid is the payer of last resort)
- Is submitted electronically if the provider has the ability to submit claims electronically

Providers may submit and check the status of claims electronically via the secure Meridian Provider Portal. To gain access to the Provider Portal, please register with the link provided below.

Submit claims via the Provider Portal:

https://provider.mimeridian.com

Submit paper claims via mail:

Date of Service	Health Plan Name	Transaction Type (CH/RP)	Clearing House Payer ID	Paper Claim Submissions
On or before March 31, 2022	**Meridian**	**Fee-for-Service BHT06 = CH**	**52563**	**Meridian ATTN: Claims Department 1 Campus Martius, Suite 710 Detroit, MI 48226**
On or after April 1, 2022	**Meridian**	**Fee-for-Service BHT06 = CH**	**MHPMI**	**Meridian ATTN: Claims Department PO Box 8080 Farmington, MO 63640-8080**

Please note: For fastest, most accurate processing, EDI is the preferred method.

Taxonomy Codes

Taxonomy Codes are designed to categorize the type, classification, and/or specialization of healthcare providers. To ensure accurate and timely claims processing and payment effective 1/1/17 Meridian will require all claims, both paper and electronic, to include the taxonomy code of the rendering provider. The taxonomy code included on the claim must also match the taxonomy code Meridian has on file for the rendering provider. To submit or update this information please complete the provider enrollment form located on our website.

Section 2: Provider Specifics

Federally Qualified Health Center (FQHC)/Freestanding Rural Health Clinic (RHC)/Encounter Rate Clinic (ERC)

FQHCs are important community providers and all Meridian members have access to them if the member resides in a community where FQHC services are available. The Member Handbook outlines the member's rights to access a FQHC in their service area. Billing requirements for FQHC/RHC for Medicaid is fee-for-service.

FQHC/RHC/ERC Billing Requirements:

- FQHC, RHC, and ERC claims must bill with the group National Provider Identifier (NPI)
- FQHC, RHC, and ERC behavioral health (BH) claims must include a BH modifier
- FQHC, RHC and ERC claims must be billed on a UB
- FQHC, RHC, and ERC encounter claims should be billed with T1015 CPT code along with services provided

FQHC Specific:

- Meridian Medicare primary: bills on a UB and is paid at CMS federal encounter rate or fee schedule, based on the services provided
- Meridian Medicaid primary: bills on a UB and is paid from the provider fee schedule
- Dual Population: Meridian processes the Medicare claim and Medicaid picks up the coinsurance

SNF Billing Requirements Medicaid:

- Must bill on a UB-04 form

Medicare:

- Must bill on a UB-04 form
- Must bill with resource utilization group (RUG)

Custodial Care:

- Must bill on a UB-04 form
- Must bill monthly
- Must include value code D3 and patient pay amount
- Must bill room and board charge only

Therapy Claims

- Therapy claims can be billed on a CMS 1500 or UB-04 form

Laboratory

- Laboratory charges can be submitted to Meridian on a CMS 1500 of UB-04 form

Prenatal

- All prenatal claims must be billed with last menstrual period date
- Dental charges for pregnant women can be submitted to Meridian
- Maternal Infant Health Program (MIHP)-related services rendered to fee-for-service (FFS) beneficiaries must be billed on the CMS 1500 professional format

Behavioral Health

The Behavioral Health department at Meridian coordinates behavioral health care for Meridian members accessing services from contracted offices and community mental health and substance abuse treatment providers in Michigan.

Listed below is an explanation of Behavioral Health services that require prior authorization and what services do not:

Please contact the Meridian Behavioral Health department at **888-222-8041** or fax **833-655-2191** if you have questions about what services require prior authorization and what services do not.

Section 3: Adjustments

Voiding and Replacement Claims

If you are replacing or voiding and replacing a UB-04 claim, use appropriate bill type of XX7 or XX8. If you are replacing or voiding and canceling a CMS 1500 claim, please complete box 22. For a replacement or corrected claim, enter resubmission code 7 in the left side of box 22 and enter the original claim number of the claim you are replacing in the right side of box 22. If you are voiding and canceling a claim, enter resubmission code 8 on the left side of box 22 and enter the original claim number of the paid claim you are voiding/canceling on the right side of box 22.

All claim completion instructions apply for a void/cancel claim except as noted below:

- Complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted using the correct member ID

After the void/cancel claim is submitted, a new claim containing the correct provider NPI and/or member ID number may be submitted

A replacement claim must be submitted when all or a portion of the claim was paid incorrectly or a third-party payment was received after Meridian made payment. When a replacement claim is received, Meridian deletes the entire original claim and replaces it with the information contained on the replacement claim. All money paid on the original claim is debited and a new payment is issued based solely on information reported on the replacement claim.

Replacement claims should be submitted to:

- Return an overpayment and provide an explanation of the reason for the overpayment in Remarks section
- Correct information submitted on the original claim (other than to correct a provider NPI and/or member ID number) and provide an explanation of what information is being corrected
- Report payment from another source after Meridian paid the claim. Report the source of the payment (e.g. Medicare) in the Remarks section
- Correct information that the scanner misread (except a provider NPI or member ID number) and state reason in the Remarks section

Use CMS approved two-digit place of service codes to report location for provision of covered services. Please refer to your Authorization Overview for all services that require authorization for in-network providers.

Submit claims via the Provider Portal:
https://provider.mimeridian.com

Submit paper claims via mail:

Date of Service	Health Plan Name	Transaction Type (CH/RP)	Clearing House Payer ID	Paper Claim Submissions
On or before March 31, 2022	**Meridian**	**Fee-for-Service BHT06 = CH**	**52563**	**Meridian ATTN: Claims Department 1 Campus Martius, Suite 710 Detroit, MI 48226**
On or after April 1, 2022	**Meridian**	**Fee-for-Service BHT06 = CH**	**MHPMI**	**Meridian ATTN: Claims Department PO Box 8080 Farmington, MO 63640-8080**

Please note: For fastest, most accurate processing, EDI is the preferred method.

Utilization Management Authorizations

For services that require prior authorizations to be approved for coverage, the Utilization Management department makes a coverage determination. All claims billed using the approved prior authorization should have the authorization number noted in the appropriate location of the form. Refer to the claim form instructions as necessary.

Billing Procedure Code Requirements

When billing for services rendered to Meridian members, providers must use the most current Medicare-approved coding format (ICD-10, CPT, HCPCS, etc.) and/or state Medicaid guidelines for claims payment.

Please follow these guidelines for claims submission to Meridian:

- Providers must use a standard CMS 1500 claim form or UB-04 claim form for submission of claims to Meridian
- Providers must use industry standard procedure and diagnosis codes such as CPT, Revenue, HCPCS, and ICD-10 when billing Meridian

Claims billed using ICD-9 codes will not be accepted for services delivered on or after 10/1/2015, and inpatient discharges occurring 10/1/2015 or after. Any claims with dates of service prior to 10/1/2015 that are billed for services delivered and inpatient discharges should use ICD-9 codes. Claims with dates of service on or after 10/1/2015 that are billed for services delivered and inpatient discharges should use ICD-10 codes. The switch over to ICD-10 does not impact CPT coding for outpatient provider services and procedures.

For more information about ICD-10 refer to:

- **http://cms.gov/Medicare/Coding/ICD10/index.html**
- **mimeridian.com/providers** and click on Bulletins/Updates. Select the Bulletin titled “Transition to ICD-10”

Tax Identification and National Provider Identifier (NPI) Requirements

- Meridian requires the Tax ID and NPI on all claims submissions, with the exception of atypical providers. Atypical providers are non-healthcare providers such as taxi drivers, carpenters and

personal care providers. These providers must preregister with Meridian before submitting claims to avoid NPI rejections

- Meridian may reject claims without the Tax ID and/or NPI. The provider's NPI must be registered with the state and on the active Medicaid provider roster. The NPI for the correct category of service must be used to have the encounter accepted by the state

National Drug Codes

Meridian follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS. Visit the CMS website at **www.cms.gov** for more information.

Modifiers

Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review.

Meridian recognizes two levels of modifiers:

- Level I modifiers are those included in CPT codes and updated annually by the American Medical Association (AMA)
- Level II modifiers are recognized nationally and updated annually by CMS

Definitions and use of Level I modifiers can be found in the annual edition of the CPT manual. Definitions of Level II modifiers are found in the annual edition of the HCPCS procedure coding manual.

Electronic Claims Submission

The preferred method for submitting claims is electronically. This can be done through clearinghouses or via the online Provider Portal.

If you are re-submitting a claim for a status or a correction, please indicate "Status" or "Claims Correction" on the claim.

Meridian is currently accepting electronic claims from the following clearinghouse:

Availity
Customer Support:
800-282-4548 Claim Types:
Professional/Facility
Payer ID: MHPMI

Meridian may add new clearinghouses from time to time. Contact Provider Services at **888-437-0606** to see if your clearinghouse partner is on the list.
Providers are responsible for ensuring that they receive a confirmation file for claims submitted via electronic data interchange (EDI).

Paper Claims Submission

To facilitate processing and to minimize chances for rejection or error in payment, it is required that paper claims be typewritten or computer printed. The recommended font to use for computer generated claims is 12-point Times New Roman font. Do not print in italics, bold or script. Handwritten

claims and photocopied claims are not accepted. Paper claims information must be submitted within the confines of each item box.

Claims must be legibly signed and dated in ink by the provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable.

An authorized representative may only be a trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. Such a representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service.

It is mandatory that claims for services be submitted only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

Timely Filing

Providers have 365 days from the date of service to submit a claim. A claim can be resubmitted or adjusted so long as it is submitted within 120 days from the last date of adjudication. If a claim is submitted for a second time and denied within that year, providers have up to one year from the last adjudication date to make corrections, however it cannot exceed two years from the date of service. No claim will be paid past two years from the date of service.

Claims must be submitted within 365 days from the date of service, or as agreed upon in the provider contract. Please note most signed contracts have a 180-day filing limit. Failure to submit claims data within the prescribed time period may result in payment delay or denial. This guidance is in accordance with CMS's expectations concerning timely submission of claims/encounter data by Medicare-Medicaid plans.

There are two exceptions to the timely filing guideline, which include:

- Retroactive eligibility: These claims must be accompanied by a Notice of Decision and received within 365 days of the notice date and reimbursed under a retrospective payment system
- Third-party related delays: These claims must be accompanied by a third-party liability (TPL) explanation of benefits and also received within 120 days of the TPL process date

Electronic Funds Transfer and Electronic Remittance

We offer a free solution for payment by Electronic Funds Transfer (EFT) and Electronic Remittance Advice (835)/Explanation of Payment (ERA/EOP) through Payspan®. Create an account by registering at **www.payspanhealth.com** or calling **1-877-331- 7154, option 1.**

Section 4: Grievance and Appeals Process

Overview

Meridian offers a post-service claim appeal process for disputes related to denial of payment for services rendered to Meridian members. This process is available to all providers, regardless of whether they are in- or out-of-network.

Appeals

An appeal is a request for review of a decision made by Meridian to deny, reduce, or terminate a requested service. A few examples are:

- A service denied based on medical necessity
- A payment denied (in whole or part) for a service
- A service denied (such as physical therapy) that was previously authorized

Members have 60 days to file an appeal from the date of the denied service. All written or verbal communication by a member regarding dissatisfaction with a decision to deny, reduce or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A provider or other authorized representative of the member such as a family member, friend or attorney may file an appeal on the member's behalf with the member's written permission. The member must submit written permission to Meridian for an authorized representative to appeal on their behalf.

Providers can submit claims disputes via mail. Effective April 1, 2022, all claims disputes for a date of service on or after April 1, 2022 should be submitted via mail or through the provider portal at provider.mimeridian.com using the guidelines and mailing addresses below. For claims on or before March 31, 2002 providers should use the claims dispute form found at https://corp.mhplan.com/en/dispute-form/.

Appeals must be submitted via mail using the address provided.

Health Plan & Correspondence Type	Date of Service	Mailing Address
MI Claim Payment Disputes (Related to untimely filing, incidental procedure, unlisted procedure code)	**On or before** March 31,2022	Meridian ATTN: Claims Department 1 Campus Martius, Suite 710 Detroit, MI 48226
	On or after April 1, 2022	Meridian Attn: Claims Department PO Box 8080 Farmington, MO 63640-8080

Members can appeal by calling Member Services toll-free at **888-437-0606** or by writing to the Meridian Appeals Coordinator at:

Meridian
ATTN: Appeals Department
P.O. Box 8080
Farmington, MO 63640-8080

Within three days of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal within 15 days of receiving all required information. Members and their PCP, as well as any other providers involved in the appeal, will be notified of the outcome of the appeal, orally and in writing, within five days of the decision.

Types of Issues Providers Can Appeal

The appeals process is in place for two main types of issues:

- The provider disagrees with a determination made by Meridian (such as combining two stays as a 15-day readmission). In this case, the provider should send additional information (such as medical records) that support the provider's position
- The provider is requesting an exception to a Meridian policy (such as prior authorization requirements). In this case, the provider must give an explanation of the circumstances and why the provider feels an exception is warranted in that specific case

How to File a Post-Service Claim Appeal

1. Send a letter explaining the nature of your appeal and any special circumstances that you would like Meridian to consider.
2. Attach a copy of the claim and documentation to support your position, such as medical records.
3. Send the appeal to the following address:

Meridian
ATTN: Appeals Department
P.O. Box 8080
Farmington, MO 63640-8080

Time Frame for Filing a Post-Service Appeal

Appeals must be filed within one year from the date of service. Meridian will allow an additional 120day grace period from the date of the last claim denial, provided that the claim was submitted within one year of the date of service. Appeals submitted after the time frame has expired will not be reviewed.

Response to Post-Service Claim Appeals

Meridian typically responds to a post-service claim appeal within 30 days from the date of receipt. If additional information is needed, such as medical records, then Meridian will respond within 30 days of receiving the necessary information. Providers will receive a letter with Meridian's decision and rationale. There is only one level of appeal available within Meridian. All appeal determinations are final. There is only one level of appeal available for post-service claim reviews. All appeal determinations are final.

If a provider disagrees with Meridian's determination regarding an appeal, the provider may pursue one of the following options depending on contract status:

- Contracted Hospitals: Binding Arbitration – A provider may initiate arbitration by making a written demand for arbitration to Meridian. The Provider and Meridian agree to mutually select an arbitrator and the process for resolution.
- Non-Contracted Hospitals may utilize the dispute procedures outlined in the Hospital Access Agreement between signatory hospitals and MDHHS, provided the hospital is a signatory to that agreement. The dispute must first be submitted to an Accounts Receivable Reconciliation Group (ARRG) in accordance with the terms of the MDHHS Hospital Access Agreement included in MSA 01-28

Provider must submit its request for Binding Arbitration or to use the procedures of the Access Agreement no later than three hundred sixty-five (365) days from the date of service, or within one hundred twenty (120) days of the last claim denial provided the initial claim was submitted within one year of the date of service. Providers will have no further recourse on any claim if they do not file their request for either of the above dispute resolution mechanisms within these timeframes.

Explanation of Payment (EOP)

Meridian sends its providers remittance vouchers as an explanation of payment.
When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider's charge and the Medicaid payment for service.

Section 5: Coordination of Benefits (COB)

Overview

Meridian is responsible only for the difference between what the primary insurance pays and the allowable Medicaid or Medicare fee screen. Please submit claims that have other insurance payers to Meridian with an attached explanation of benefits (EOB) payment or rejection. Attach EOB information in the correct 837i, 837p, or 837d format when sending in a claim electronically. A paper remit is not required.

Transition of Care

Medicaid Members

Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as (but not limited to) other health care plans or workers' compensation benefits. In the event that Meridian is not the only insurance coverage for the member, Meridian should be billed as secondary payer for all services rendered, and is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee schedule. Please submit claims that have other insurance payers to Meridian with an attached EOB payment or rejection.

Claims Guidelines for Dual-Eligible Members

Services provided to patients who are covered by Meridian for both Medicare and Medicaid should follow the guidelines below:

- Submit one authorization request to Meridian – Meridian will coordinate authorization requirements, benefits and services between the two products
- Submit one claim to Meridian. There is no need to submit two claims. Claims processing information will be reported on two remittance advice (RA) forms:

- The 1st RA will come from Meridian Medicare indicating how the claim was processed and informing you that the claim was forwarded to Meridian Medicaid for secondary processing
- The 2nd RA will show how the claim was processed by Meridian Medicaid

Third Party Liability and Subrogation

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a member's healthcare coverage. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to make themselves whole. The contractor may retain all such collections. If TPL resources are available, the Contractor is not required to pay the provider first and then recover money from the third party; however, the contractor may elect to "pay and chase." Contractors may research, identify and recover all sources of third party funds based on industry standards. The contractor must follow Medicaid Policy regarding TPL. The contractor must report third party collections in its encounter data submission and in aggregate as required by MDHHS.

The provider must provide proof of attempts made to identify third party payers when submitting claims.

When an enrollee is also enrolled in Medicare, Medicare will be the primary payer ahead of any contractor. The contractor must make the enrollee whole by paying or otherwise covering all Medicare cost sharing amounts incurred by the enrollee such as coinsurance and deductibles.

Section 6: Fraud, Waste and Abuse Overpayment and Recovery

Overpayment and Recovery

Meridian determines how to handle recovery of overpayments ("take-backs") according to the situation that created the overpayment and the time frame between when the payment was made and when the overpayment was identified.

- Inaccurate payment: This includes duplicate payment, system set-up error, claims processing error and claims paid to the wrong provider. Adjustment/notification date for recovery will be limited to 12 months from date of payment
- Identified through a medical record audit: Adjustment/notification date for recovery will be limited to 12 months from date of payment. In the event that the audit reveals fraud, waste or abuse, the 12 month look back period will no longer apply
- Fraud and abuse: Adjustment/notification date for recovery time period will be the statute of limitations or the time limit stated in the Provider Agreement

In the event it is determined that an inaccurate payment was made, Meridian will not provide prior written notice of a recovery. In that case, Meridian will recover the overpayment by issuing an invoice or performing a "take-back". Full details of this recovery will be provided in either the invoice or the remittance advice.

No time limit applies to the initiation of overpayment recovery efforts required by a state or federal program or where fraud is suspected or intentional misconduct is involved.

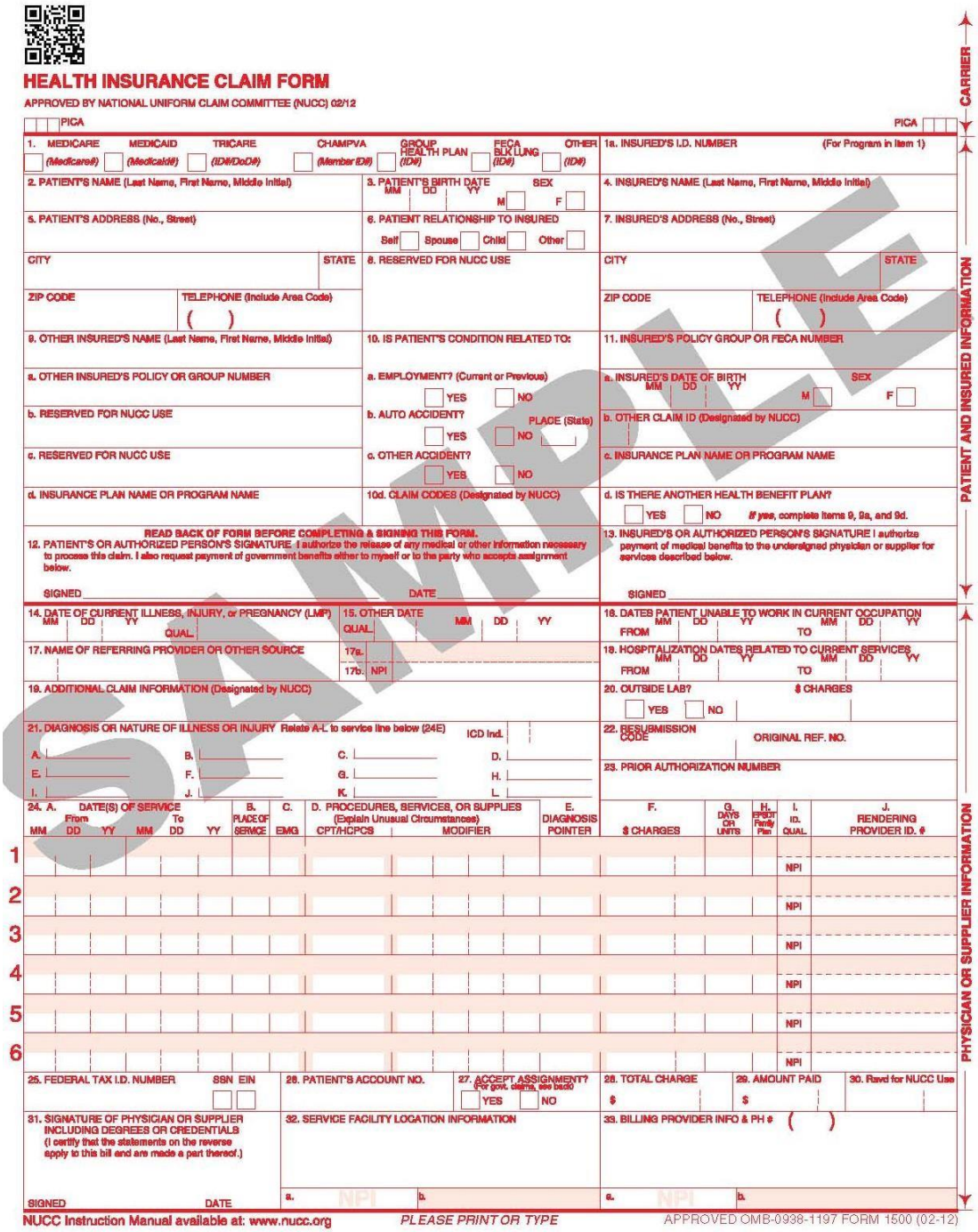
Medical Record Access

All medical records requested by Meridian are to be provided at no cost from the provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor.

Medical records should be provided to Meridian within 10 business days of request, unless otherwise agreed. To help ease the burden on providers, accommodations can be arranged for individuals designated by Meridian to assist in extracting medical records for this request. Electronic access to medical records should be arranged wherever possible.

Appendix I: Sample CMS Forms

Sample CMS 1500 Form



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)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? 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 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 PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Key: R =Required S =Situational (Only if appropriate to this claim) NR= Not Required

Form Number	Requirements	Form Label	Specifics
1	R	Type of Health Insurance Coverage	Select the correct type of coverage.
1a	R	Insured ID Number	Enter the member's ID number from the Meridian ID card
1	R	Patient's Name	Enter the patient's last name, first name and middle initial
2	R	Patient's Birth Date/Sex	Enter the patient's date of birth using the six-digit format (MM/DD/YY). Next, select the patient's gender.
3	R	Insured's Name	Enter the insured's last name, first name and middle initial.
4	R	Patient's Address/Telephone Number	Enter the patient's permanent mailing address and telephone number
5	R	Patient's Relationship To The Insured	Select the appropriate box for the patient's relationship to the insured person.
6	R	Insured's Address/Telephone Number	Enter the insured person's permanent mailing address (complete if different from the patient's address)
7	S	Reserved for NUCC Use	
9	NR	Other Insured's Name	Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.
9a	S	Other Insured's Policy or Group Number	Enter the other insured person's policy or group number.
9b	NR	Reserved For NUCC Use	Enter the insured person's date of birth using the six-digit format (MM/DD/YY).
9c	NR	Reserved for NUCC Use	Enter the other insured person's employer or school name.
9d	S	Insurance Plan Name or Program Name	Enter the name of the other insured person's insurance plan or program name.

10a-d	S	Is Patient's Condition Related To:	For 10a-10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure,

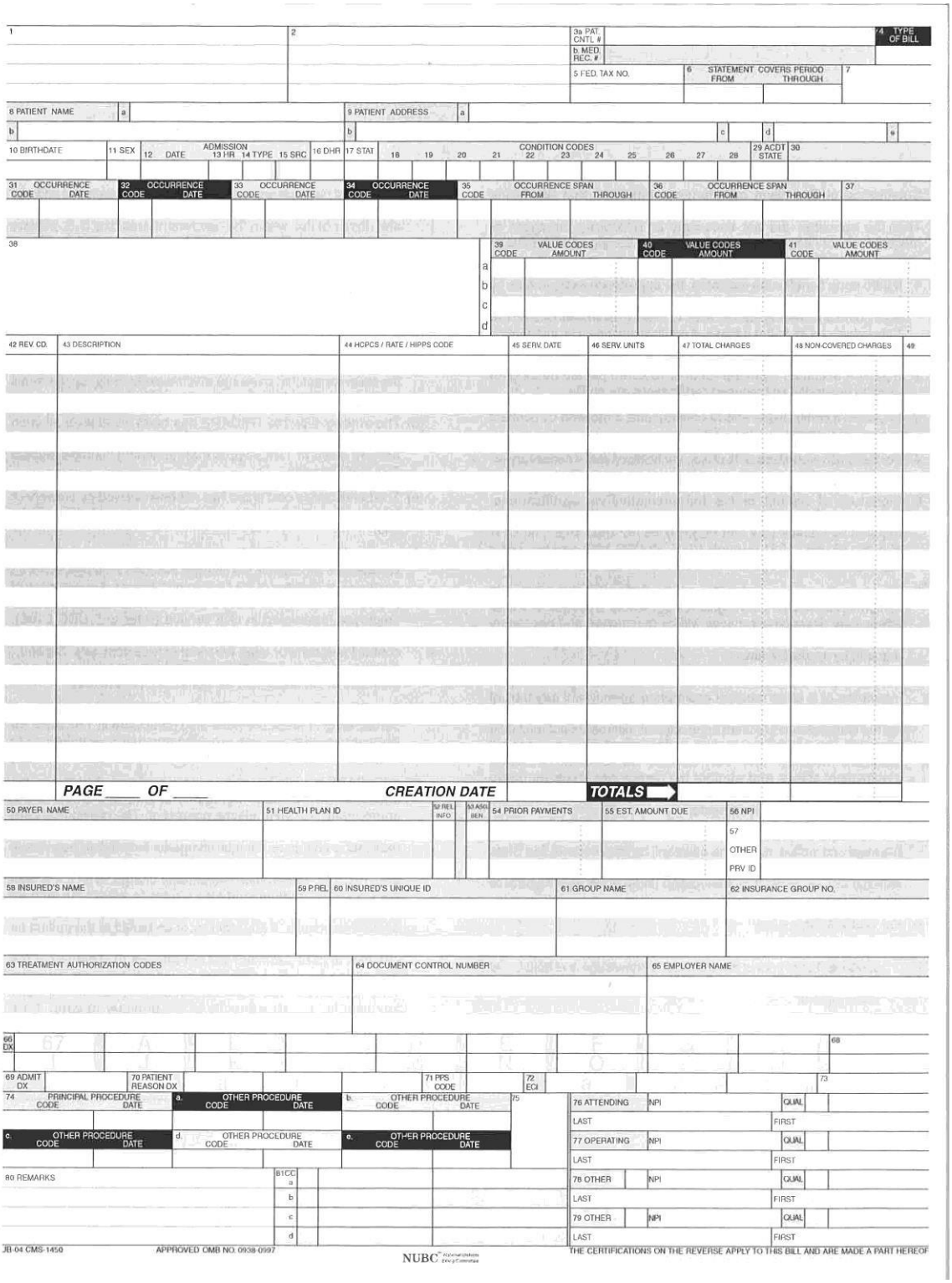
			leave blank.
10a	S		Select whether the patient's condition is related to employment
10b	S		Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation, i.e. MI.
10c	S		Select whether the patient's condition is related to any other type of accident.
10d	NR	Claim Codes (Designated by NUCC)	Not Required.
11	R	Insured's Policy Group or FECA number	Not Required
11a	R	Insured's Date of Birth/Sex	Enter the subscriber's date of birth using the six-digit date format (MM/DD/YY) and select the subscriber's gender.
12	NR	Patient or Authorized Person's Signature	Not Required
13	NR	Insured or Authorized Person's Signature	Not Required
14	S	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the date using the six-digit date format (MM/DD/YY).
15	S	Other Date	Enter the date using the six-digit date format (MM/DD/YY).
16	S	Dates Patient Unable to Work in Current Occupation.	Enter the date using the six-digit date format (MM/DD/YY).
17	S	Name of Referring Provider or Other Source	Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials.
17a	NR	Other ID#	Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).
17b	S	NPI#	Enter the 10-digit NPI number of the referring, ordering or supervising provider.

18	S	Hospital Dates Related to Current Services	Enter the hospital dates using the six-digit date format (MM/DD/YY).
19	NR	Additional Claim Information	Not required.
20	R	Outside Lab/Charges	Select “Yes” or “No” to indicate if the claim includes charges for lab services performed outside of the provider’s office. If “Yes”, enter the total charges.
21	R	Diagnosis or Nature of Illness or Injury	Enter the ICD-10 CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional diagnosis codes can be entered.
22	NR	Resubmission	Not required.
23	NR	Prior Authorization Number	Not required.
24		Shaded Area – Supplemental Information	The shaded area of field 24a-24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee’s (NUCC) website at **www.nucc.org**.
24	R	Date(s) of Service	Enter the dates of service using the six-digit date format (MM/DD/YY).
24B	R	Place of Service	Enter the appropriate two-digit Place of Service code.
24C	S	EMG	If this service was an emergency, enter “Y” for Yes, or leave blank if No.
24D	R	Procedures, Services, or Supplies	Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable.
24E	R	Diagnosis Pointer	Enter the appropriate ICD-10 CM diagnosis code or codes for each procedure performed. Enter one code per line of service.
24F	R	Charges	Enter the charge for each line of service. Do not include discounts.
24G	R	Days or Units	Enter the number of days or units for each line of service.

24H	S	EPSDT/Family Plan	If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code.
24I	R	ID Qualifier – Shaded Field	Not Required
24J	R	Rendering Provider ID # – Shaded Field	Required Enter the provider's taxonomy code
25	R	Federal Tax ID Number	Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.
26	S	Patient Account Number	Enter account number assigned to the patient if applicable.
27	R	Accept Assignment	Select "Yes" if the provider should be paid, or select "No" if the patient should be paid.
28	R	Total Charge	Enter the total charge for all
			services.
29	S	Amount Paid	Enter any amount paid by the patient only.
30	NR	RSVD for NUCC Use	Enter the difference, if any, between the total charge and the amount paid.
31	R	Signature of Provider or Supplier Include Degrees or Credentials	The claim must be signed by the provider/supplier or an authorized representative. The form must also be dated using the six-digit date format (MM/DD/YY)
32	S	Service Facility Location Information	Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.
32a	S	NPI	Enter the 10-digit NPI number of the service facility location.
32b	NR	Other ID#	Not required
33	R	Billing Provider Info and PH#	Enter the information of the billing provider or supplier to be paid for services.
33a	R	NPI	Enter the 10-digit NPI number of the billing provider.
33b	NR	Other ID#	Not required

Appendix II: Sample UB-04 Forms

Sample UB Form



Key: R =Required S =Situational (Only if appropriate to this claim) NR= Not Required

Form Number	Requirements	Form Label	Specifics
1	R	Billing Provider Name, Address & Telephone Number	Enter the billing name, street address, city, state, zip code and telephone number of the billing provider submitting the claim. Note: this should be the facility address.
2	S	Pay To Name and Address	Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent. Note: This is required when information is different from the billing provider's information in form number 1.
3A	R	Patient Control Number	Enter the patient's unique alphanumeric control number assigned to the patient by the provider.
3B	S	Medical Record Number	Enter the number assigned to the patient's medical health record by the provider.
4	R	Type of Bill	Enter the appropriate code that indicates the specific type of bill such as inpatient, outpatient, late charges, etc. For more information on Type of Bill, refer to the National Uniform Billing Committee's (NUBC) Official UB04 Data Specifications Manual.
5	R	Federal Tax Number	Enter the provider's Federal Tax Identification number.
6	R	Statement Covers Period (From/Through)	Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 010107.
7	NR		Reserved for assignment by the NUBC. Providers do not use this field.

8A	S	Patient Name/Identifier	Enter the patient's identifier. Note: The patient identifier is situational/conditional, if different than what is in form number 60 (Insured's Subscriber/Insured's Identifier).
8B	R	Patient Name	Enter the patient's last name, first name and middle initial.
9	R	Patient Address	Enter the patient's complete mailing address (fields 9a – 9e), including street address (9a), city (9b), state (9c), zip code (9d) and country code (9e), if applicable to the claim.
10	R	Patient Birth Date	Enter the patient's date of birth using an eight-digit date format (MMDDYYYY). For example: 01281970.
11	R	Patient Sex	Enter the patient's gender using an "F" for female, "M" for male or "U" for unknown.
12	S	Admission/Start of Care Date (MMDDYY)	Enter the start date for this episode of care using a six-digit format (MMDDYY). For inpatient services, this is the date of admission. For other (Home Health) services, it is the date the episode of care began. Note: This is required on all inpatient claims.
13	S	Admission Hour	Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. Note: Required on all inpatient claims, except TOB 021X. For more information on Admission Hour, refer to the NUBC's Official UB-04 Data Specifications Manual.

14	R	Priority (Type) of Visit	Enter the appropriate code indicating the priority of this admission/visit. For more information on Priority (Type) of Visit, refer to the NUBC's Official UB-04 Data Specifications Manual.
15	R	Point of Origin for Admission or Visit	Enter the appropriate code indicating the point of patient origin for this admission or visit. For more information on Point of Origin for Admission or Visit, refer to the NUBC's Official UB-04 Data Specifications Manual.
16	S	Discharge Hour	Enter the appropriate two-digit

			discharge code referring to the hour during which the patient was discharged. Note: Required on all final inpatient claims.
17	R	Patient Discharge Status	Enter the appropriate two-digit code indicating the patient's discharge status. Note: Required on all inpatient, observation, or emergency room care claims.
18-28	S	Condition Codes	Enter the appropriate two-digit condition code or codes if applicable to the patient's condition.
29	S	Accident State	Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.
30	NR		Reserved for assignment by the NUBC. Providers do not use this field.
31-34	S	Occurrence Codes/Dates (MMDDYY)	Enter the appropriate two-digit occurrence codes and associated dates using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition.

35-36	S	Occurrence Span Codes/Dates (From/Through) (MMDDYY)	Enter the appropriate two-digit occurrence span codes and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time.
37	NR		Reserved for assignment by the NUBC. Providers do not use this field.
38	S	Responsible Party Name and Address (Claim Addressee)	Enter the name, address, city, state and zip code of the party responsible for the bill.
39-41	S	Value Codes and Amount	Enter the appropriate two-digit value code and value if there is a value code and value appropriate for this claim.
42	R	Revenue Code	Enter the applicable Revenue Code for the services rendered. For more information on Revenue
			Codes, refer to the NUBC's Official UB-04 Data Specifications Manual.
43	R	Revenue Description	Enter the standard abbreviated description of the related revenue code categories included on this bill. See form number 42 for description of each revenue code category. Note: The standard abbreviated description should correspond with the Revenue Codes as defined by the NUBC. For more information on Revenue Description, refer to the NUBC's Official UB-04 Data Specifications Manual.

44	S	HCPCS/RATES/HIPPS Code	Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy. HCPCS and HIPPS Rate Codes: Situational. Required for outpatient claims when an appropriate HCPCS code exists for this service line item. Accommodation Rates: Situational. Required when a room & board revenue code is reported. HCPCS Modifiers: Situational. Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.
45	S	Service Date (MMDDYY)	Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, SNF\Prospective Payment System assessment date, or needed to report the creation date for line 23. For more information on Service Dates, refer to the NUBC's Official UB-04 Data Specifications Manual.
46	R	Service Units	Enter the number of units
			provided for the service line item.
47	R	Total Charges	Enter the total charges using Revenue Code 0001. Total charges include both covered and noncovered services. For more information on Total Charges, refer to the NUBC's Official UB-04 Data Specifications Manual.

48	S	Non-Covered Charges	Enter any non-covered charges as it pertains to related Revenue Code. For more information on Non-Covered Charges, refer to the NUBC's Official UB-04 Data Specifications Manual.
49	NR		Reserved for assignment by the NUBC. Providers do not use this field.
50	R	Payer Name	Enter the health plan that the provider might expect some payment from for the claim.
51	R	Health Plan Identification Number	Enter the number used by the primary (51a) health plan to identify itself. Enter a secondary (51b) or tertiary (51c) health plan, if applicable.
52	R	Release of Information	Enter a "Y" or "I" to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier.
53	R	Assignment of Benefits	Enter a "Y", "N" or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider for the primary payer (53a). Enter a secondary (53b) or tertiary (53c) payer, if applicable.
54	S	Prior Payments	Enter the amount of payment the provider has received (to date) from the payer toward payment of the claim.
55	S	Estimated Amount Due	Enter the amount estimated by the provider to be due from the payer.
56	R	National Provider Identifier	Enter the billing provider's 10-digit

		(NPI)	NPI number.

57	S	Other Provider Identifier	Required on or after the mandated NPI Implementation date when NPI is not used in FL 56 and an identification number other than the NPI is necessary to identify the provider.
58	R	Insured's Name	Enter the name of the individual (primary – 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b and 58c).
59	R	Patient's Relationship to Insured	Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b and 59c).
60	R	Insured's Unique Identifier	Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b and 60c).
61	S	Insured's Group Name	Enter insured's employer group name (61a). If applicable, enter other insured's employer group names when other payers are known to be involved (61b and 61c).
62	R	Insured's Group Number	Enter insured's employer group number (62a). If applicable, enter other insured's employer group numbers when other payers are known to be involved (62b and 62c).
63	S	Treatment Authorization Codes	Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).

64	S	Document Control Number	Enter if this is a void or
		(DCN)	replacement bill to a previously adjudicated claim (64a – 64c).
65	S	Employer Name	Enter when the employer of the insured is known to potentially be involved in paying claims. For more information on Employer Name, refer to the NUBC's Official UB-04 Data Specifications Manual.
66	R	Diagnosis and Procedure Code Qualifier	Enter the required value of "9." Note: "0" is allowed if ICD-10 is named as an allowable code set under HIPAA. For more information, refer to the NUBC's Official UB-04 Data Specifications Manual.
67	R	Principal Diagnosis Code and Present on Admission Indicator	Enter the principal diagnosis code for the patient's condition. For more information on POAs, refer to the NUBC's Official UB-04 Data Specifications Manual.
67A-67Q	S	Other Diagnosis Codes	Enter additional diagnosis codes if more than one diagnosis code applies to claim.
68	NR		Reserved for assignment by the NUBC. Providers do not use this field.
69	S	Admitting Diagnosis Code	Required when a claim involves an inpatient admission.
70	S	Patient's Reason For Visit	Enter the appropriate reason for visit code only for bill types 013X and 085X and 045X, 0516, 0526, or 0762 (observation room).
71	S	Prospective Payment System (PPS) Code	Enter the DRG based on software for inpatient claims when required under contract grouper with a payer.
72	S	External Cause of Injury (ECI) Code	Enter the cause of injury code or codes when injury, poisoning or adverse effect is the cause for seeking medical care.

73	NR		Reserved for assignment by the NUBC. Providers do not use this field.
74	S	Principal Procedure Code and Date (MMDDYY)	Enter the principal procedure code and date using a six-digit format (MMDDYY) if the patient has undergone an inpatient
			procedure. Note: Required on inpatient claims.
74A-E	S	Other Procedure Codes and Dates (MMDDYY)	Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure. Note: Required on inpatient claims.
75	NR		Reserved for assignment by the NUBC. Providers do not use this field.
76	S	Attending Provider Name and Identifiers	Enter the attending provider's NPI number, last name and first name. Situational: Not required for nonscheduled transportation claims. For more information on Attending Provider, refer to the NUBC's Official UB-04 Data Specifications Manual.
77	S	Operating Provider Name and Identifiers	Enter the operating provider's NPI number, last name and first name. Required when a surgical procedure code is listed on the claim. For more information on Operating Provider, refer to the NUBC's Official UB-04 Data Specifications Manual.
78-79	S	Other Provider Name and Identifiers	Enter any other provider's NPI number, last name and first name. For more information on Other Provider, refer to the NUBC's Official UB-04 Data Specifications Manual.

80	S	Remarks	Enter any information that the provider deems appropriate to share that is not supported elsewhere.
81CC A-D	S	Code-Code Field	Report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. Note: To further identify the billing provider (FL01), enter the taxonomy code along with the "B3" qualifier. For more information on requirements for
			form number 81, refer to the NUBC's Official UB-04 Data Specifications Manual.
Line 23	S		Line 23 contains an incrementing page and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

***All services require prior authorization. Existing care plan service will not require authorization for first 180 days.**

Appendix III: Electronic Funds Transfer and Electronic Remittance

We offer a free solution for payment by Electronic Funds Transfer (EFT) and Electronic Remittance Advice (835)/Explanation of Payment (ERA/EOP) through Payspan®. Create an account by registering at www.payspanhealth.com or calling 1-877-331-7154, option 1.

If you have any questions or concerns please contact your local Provider Network Development Representative or the Provider Services department directly at 888-437-0606.

Appendix IV: Third Party Coverage

Topic	Description
Identification of Third-Party Resources	Providers must always identify third party resources and report third party payments in the appropriate item(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Commercial Insurance Payments	If payments are made by a commercial insurance, the EOB must be submitted with the claim.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the remaining Medicaid liability for the service in Item 24F of the service line on the CMS 1500 paper form.
Evidence of Other Insurance Response	When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing for covered services. If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.
Injectable Drugs Covered as a Pharmacy Benefit by Third Party Payers	When billing for injectable drugs that are covered as a pharmacy benefit by a third-party payer but covered as a provider service by Medicaid, the provider must reflect the payment from the carrier on the claim. The fixed copay/coinsurance/deductible must be reported in the appropriate field on the electronic claim form and in Item 24F on the CMS 1500 paper form.