Claims Inputs

03/29/2016

Input Forms CP-F-009-02 EXCLUDED

Header Record to determine date for selection of subsequent data.

Subsystem:	Claims
Source/Originator:	A9125
Frequency:	N/A
Estimated Volume:	
Programs:	N/A
Proc/Screen ID:	To Be Determined
Graphics:	N/A

Field Definitions

#	Field Name	Data Element Name	Element ID
N/A			

Input Forms CP-F-950 Medicaid PA Action Reason File

VA Medicaid PA Action Reason Code File

Subsystem:	Claims
Source/Originator:	
Frequency:	N/A
Estimated Volume:	N/A
Programs:	N/A
Proc/Screen ID:	To Be Determined
Graphics:	N/A

Field Definitions

#	Field Name	Data Element Name	Element ID
N/A			

Input Forms CP-I-01 UB Claim Form

This is the form for submitting institutional claims. The same input information is available from EMC transmissions.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper UB04 Capture (CPI014)
Proc/Screen ID:	To Be Determined

UB Claim Form (CP-I-01)

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

8 PATIENT NAME | 9 PATIENT ADDRESS

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

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

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	PAGE ____ OF ____	CREATION DATE		TOTALS			

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

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

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A | B | C | D | E | F | G | H | 68
I | J | K | L | M | N | O | P | Q

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

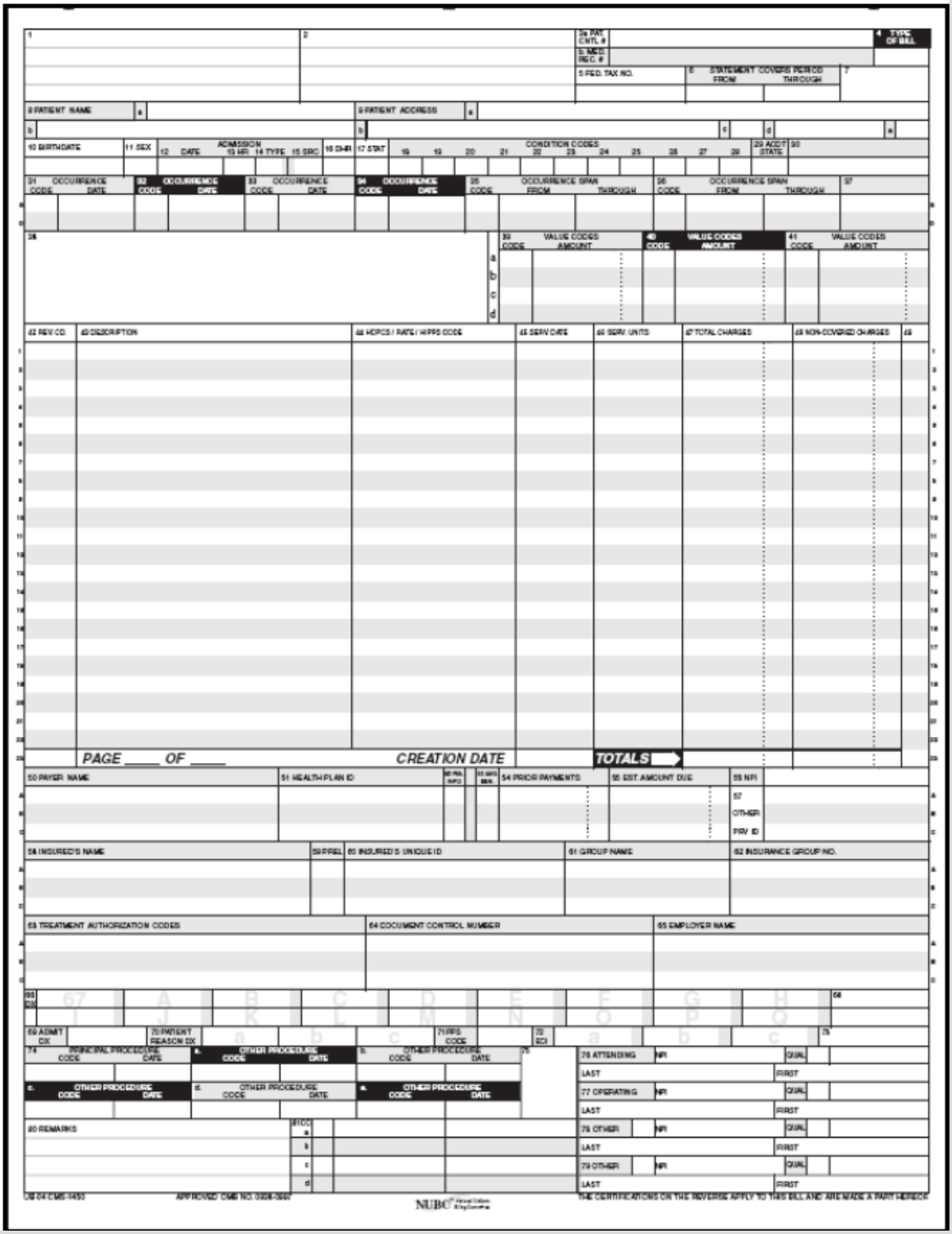
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81 CC a b c d

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

UB Claim Form (CP-I-01)



Field Definitions

#	Field Name	Data Element Name	Element ID
1	PROVIDER NAME & ADDRESS		DE0000
2	Provider Name and Address		DE0000

3	PATIENT CONTROL NO.	Claim Patient Account Number	DE2031
3.2	MEDICAL RECORD NO.	Claim Medical Record Number	DE2845
4	TYPE OF BILL	Claim Facility Bill Type	DE2102
5	FED. TAX NO.		DE0000
6	STATEMENT COVERS PERIOD FROM	Claim Service From Date	DE2010
6.1	STATEMENT COVERS PERIOD THROUGH	Claim Service Thru Date	DE2011
7	Blank Field		DE0000
8	PATIENT NAME	Person Name	DE1001
9	PATIENT ADDRESS		DE0000
10	BIRTHDATE		DE0000
11	SEX		DE0000
12	ADMISSION DATE	Claim Admission Date	DE2105
13	ADMISSION HR	Claim Hour of Admission	DE2136
14	ADMISSION TYPE	Claim Nature of Admission	DE2107
15	ADMISSION SRC	Claim Admission Source	DE2106
16	D HR	Claim Hour of Discharge	DE2412
17	STAT	Claim Discharge Status	DE2869
18	CONDITION CODES (1)	Claim Condition Code	DE2115
19	CONDITION CODES (2)	Claim Condition Code	DE2115
20	CONDITION CODES (3)	Claim Condition Code	DE2115
21	CONDITION CODES (4)	Claim Condition Code	DE2115
22	CONDITION CODES (5)	Claim Condition Code	DE2115
23	CONDITION CODES (6)	Claim Condition Code	DE2115
24	CONDITION CODES (7)	Claim Condition Code	DE2115
25	CONDITION CODES (8)	Claim Condition Code	DE2115
26	CONDITION CODES (9)	Claim Condition Code	DE2115
27	CONDITION CODES (10)	Claim Condition Code	DE2115
28	CONDITION CODES (11)	Claim Condition Code	DE2115
29	Accident State	Accident State	DE2057
30	(Blank Field)		DE0000
31	OCCURRENCE CODE (1) (a, b)	Claim Occurrence Code	DE2110
31.1	OCCURRENCE DATE (1) (a, b)	Claim Occurrence From Date	DE2113
32	OCCURRENCE CODE (2) (a, b)	Claim Occurrence Code	DE2110
32.1	OCCURRENCE DATE (2) (a, b)	Claim Occurrence From Date	DE2113
33	OCCURRENCE CODE (3) (a, b)	Claim Occurrence Code	DE2110
33.1	OCCURRENCE DATE (3) (a, b)	Claim Occurrence From Date	DE2113
34	OCCURRENCE CODE (4) (a, b)	Claim Occurrence Code	DE2110

34.1	OCCURRENCE DATE (4) (a, b)	Claim Occurrence From Date	DE2113
35	OCCURRENCE SPAN CODE (a, b)	Claim Occurrence Code	DE2110
35.1	OCCURRENCE SPAN FROM (a, b)	Claim Occurrence From Date	DE2113
35.2	OCCURRENCE SPAN THROUGH (a, b)	Claim Occurrence Thru Date	DE2114
36	OCCURRENCE SPAN CODE (a, b)	Claim Occurrence Code	DE2110
36.1	OCCURRENCE SPAN FROM (a, b)	Claim Occurrence From Date	DE2113
36.2	OCCURRENCE SPAN THROUGH (a, b)	Claim Occurrence Thru Date	DE2114
37	Local Use - Former Reference Number	Claim Related Document Number	DE2034
37.1	Local Use - Former Reference Number	Claim Related Document Number	DE2034
38	(Blank Field) (a-d)		DE0000
39	VALUE CODES CODE (1) (a-d)	Claim COB Indicator	DE2544
39.1	VALUE CODES AMOUNT (1) (a-d)	Claim Third Party Payment	DE2018
40	VALUE CODES CODE (2) (a-d)	Claim COB Indicator	DE2544
40.1	VALUE CODES AMOUNT (2) (a-d)	Claim Third Party Payment	DE2018
41	VALUE CODES CODE (3) (a-d)	Claim COB Indicator	DE2544
41.1	VALUE CODES AMOUNT (3) (a-d)	Claim Third Party Payment	DE2018
42	REV. CD. (1-23)	Claim Revenue Code	DE2122
43	DESCRIPTION (1-23)	Procedure Short Name	DE5015
44	HCPCS/RATES (1-23)	Procedure Code	DE5002
45	SERV. DATE (1-23)		DE0000
46	SERV. UNITS (1-23)	Claim Number of Unit-s/Visits/Studies	DE2009
47	TOTAL CHARGES (1-23)	Claim Total Document Charge	DE2017
48	NON-COVERED CHARGES (1-23)	Claim Non-Covered Amount	DE2139
49	(Blank Field) (1-23)		DE0000
50	PAYER (A-C)		DE0000
51	Health Plan ID (A-C)		DE0000
52	REL INFO (A-C)		DE0000
53	ASG BEN (A-C)		DE0000
54	Prior Payments	Claim Patient Pay Amount	DE2083
55	EST. AMOUNT DUE (A-C)		DE0000
56	NPI	National Provider Identifier	DE4700
57	Other Provider ID	Claim Billing Provider Identification Number	DE2004
58	INSURED'S NAME (A-C)	Claim Other Insured's Name	DE2522
59	P. REL (A-C)	Relationship to Patient	DE2352
60	CERT-SSN-HIC-ID NO. (A-C)	Enrollee Identification Number	DE3001

61	GROUP NAME (A-C)	Claim Other Insured's Name	DE2522
62	INSURANCE GROUP NO. (A-C)	Claim Group Number or FECA Number (Insurance)	DE2516
63	TREATMENT AUTHORIZATION CODES (A-C)	Prior Authorization Control Number	DE2024
64	DOCUMENT CONTROL NUMBER		DE0000
65	EMPLOYER NAME (A-C)	Claim Employer Name	DE2517
66	DIAGNOSIS VERSION QUALIFIER		DE0000
67	PRIN. DIAG. CD.	Diagnosis Code	DE5301
67.01	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.02	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.03	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.04	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.05	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.06	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.07	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.08	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.09	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.1	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.11	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.12	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.13	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.14	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.15	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.16	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
67.17	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
68.1	Void/Adjustment Reason Code	Adjustment/Void Reason	DE2033
69	ADM. DIAG. CD.	Diagnosis Code	DE5301
70	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
70.1	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
70.2	OTHER DIAG. CODES CODE	Diagnosis Code	DE5301
72	E-CODE	Diagnosis Code	DE5301
72.1	E-CODE	Diagnosis Code	DE5301
72.2	E-CODE	Diagnosis Code	DE5301
74	PRINCIPAL PROCEDURE CODE	Procedure Code	DE5002
74.01	PRINCIPAL PROCEDURE DATE	Claim Procedure Code Date	DE2021
74.02	OTHER PROCEDURE CODE (A-E)	Procedure Code	DE5002
74.03	OTHER PROCEDURE DATE (A-E)	Claim Procedure Code Date	DE2021

75	BLANK		DE0000
76	Attending Provider NPI	National Provider Identifier	DE4700
76.2	ATTENDING PHYS. ID	Claim Attending Provider Identification Number	DE2060
78	Other Provider NPI	National Provider Identifier	DE4700
78.1	OTHER PHYS. ID (A)	Claim Attending Provider Identification Number	DE2060
79	Other Provider NPI	National Provider Identifier	DE4700
79.1	OTHER PHYS. ID (B)	Claim Attending Provider Identification Number	DE2060
80	REMARKS (a-d)		DE0000
81	Code	NPI-API Label	DE4701
82	(OCR/Original)	Claim Request ICN	DE2001

Input Forms CP-I-02 CMS-1500 Claim Form

This is the form for submitting non-institutional claims. The same input information is available from EMC transmissions.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper CMS-1500 Capture (CPI012)
Proc/Screen ID:	To Be Determined

CMS-1500 Claim Form (CP-I-02)

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE 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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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) 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 govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

Field Definitions

#	Field Name	Data Element Name	Element ID
1	(CLAIM PROGRAM/BENEFIT INDICATOR)		DE0000
1.1	INSURED'S I.D. NUMBER	Enrollee Identification Number	DE3001
2	PATIENT'S NAME		DE0000
3	PATIENT'S BIRTHDATE		DE0000
3.1	PATIENT'S SEX		DE0000
4	INSURED'S NAME	Claim Other Insured's Name	DE2522
5	PATIENT'S ADDRESS		DE0000
6	PATIENT'S RELATIONSHIP TO INSURED	TPL Relationship Code	DE3704
7	INSURED'S ADDRESS		DE0000
8	RESERVED FOR NUCC USE		
9	OTHER INSURED'S NAME	Claim Other Insured's Name	DE2522
9.1	OTHER INSURED'S POLICY OR GROUP NUMBER	Claim Group Number or FECA Number (Insurance)	DE2516
9.2	RESERVED FOR NUCC USE		DE0000
9.3	RESERVED FOR NUCC USE		DE0000
9.4	EMPLOYER'S NAME OR SCHOOL NAME	Claim Name and Address of Other Carrier(s)	DE2534
9.5	INSURANCE PLAN NAME OR PROGRAM NAME	Claim Insured's Plan Name or Program Name	DE2527
10.1	IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT?	Claim Employment Indicator	DE2074
10.2	IS PATIENT'S CONDITION RELATED TO: AUTO ACCIDENT?	Claim Auto Accident	DE2431
10.3	IS PATIENT'S CONDITION RELATED TO: OTHER ACCIDENT?	Claim Other Accident Indicator	DE2028
10.4	CLAIM CODES(DESIGNATED BY NUCC)		DE0000
11	INSURED'S POLICY GROUP OR FECA NUMBER	Insured Plan Number	DE2446
11.1	INSURED'S DATE OF BIRTH	Claim Other Insured's Date of Birth	DE2524
11.2	OTHER CLAIM ID (DESIGNATED BY NUCC)	Other Claim Id	DE0000
11.3	INSURANCE PLAN NAME OR	Claim Insured's Plan Name or Program	DE2527

	PROGRAM NAME	Name	
11.4	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Claim COB Indicator	DE2544
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		DE0000
12.1	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE		DE0000
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		DE0000
14	DATE OF CURRENT: ILLNESS, INJURY, OR PREGNANCY	Claim Date of Illness/Injury/Pregnancy	DE2209
14.1	QUALIFIER		DE0000
15	OTHER DATE		DE0000
15.1	QUALIFIER		DE0000
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM		DE0000
16.1	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: TO		DE0000
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		DE0000
17.1	I.D. NUMBER OF REFERRING PHYSICIAN	Claim Attending Provider Identification Number	DE2060
17.2	REFERRING PROVIDER NPI	Claim Attending Provider Identification Number	DE2060
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM	Claim Hospital Start Date	DE2410
18.1	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: TO	Claim Hospital End Date	DE2411
19	CLIA Number	CLIA Certification Number	DE4318
20	OUTSIDE LAB	Claim Professional Lab Indicator	DE2174
20.1	$ CHARGES		DE0000
21.A	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.B	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.C	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.D	DIAGNOSIS OR NATURE OF	Diagnosis Code	DE5301

	ILLNESS OR INJURY		
21.E	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.F	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.G	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.H	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.I	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.J	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.K	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
21.L	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis Code	DE5301
22	MEDICAID RESUBMISSION CODE	Adjustment/Void Reason	DE2033
22.1	ORIGINAL REF. NO.	Claim Related Document Number	DE2034
23	PRIOR AUTHORIZATION NUMBER	Prior Authorization Control Number	DE2024
24.001	SUPPLEMENTAL DATA		DE0000
24.01	DATES OF SERVICE: FROM (1-6)	Claim Service From Date	DE2010
24.012	NPI	National Provider Identifier	DE4700
24.02	DATES OF SERVICE: TO (1-6)	Claim Service Thru Date	DE2011
24.03	PLACE OF SERVICE (1-6)	Claim Professional Place of Service	DUE
24.04	EMG	Claim Emergency Identifier	DE2802
24.05	PROCEDURES, SERVICES, OR SUPPLIES: CPT / HCPCS	Procedure Code	DE5002
24.06	PROCEDURES, SERVICES, OR SUPPLIES: MODIFIER	Claims Procedure Code Modifier	DE2171
24.07	DIAGNOSIS CODE	Diagnosis Code	DE5301
24.08	$ CHARGES	Claim Billed Charge	DE2016
24.09	DAYS OR UNITS	Claim Number of Units/Visits/Studies	DE2009
24.1	EPSDT FAMILY PLAN	Claim Family Planning/EPSDT Indicator	DE2075
24.11	ID QUAL		DE0000
24.12	TAXONOMY OR API		DE0000
25	FEDERAL TAX I.D. NUMBER	Provider Alternate ID Value	DE4044
25.1	(FEDERAL TAX I.D. NUMBER) SSN EIN (INDICATOR)	Provider Alternate ID Value	DE4044

26	PATIENT'S ACCOUNT NO.	Claim Patient Account Number	DE2031
27	ACCEPT ASSIGNMENT?		DE0000
28	TOTAL CHARGE	Claim Total Document Charge	DE2017
29	AMOUNT PAID	Claim Patient Pay Amount	DE2083
30	RSVD FOR NUCC USE		DE0000
31	SIGNATURE OF PYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS		DE0000
31.1	DATE		DE0000
32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED		DE0000
33	PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		DE0000
33.1	NPI	National Provider Identifier	DE4700
33.2	GRP #	Claim Billing Provider Identification Number	DE2004
34	ICN	Claim Request ICN	DE2001

Input Forms CP-I-03 ADA (DENTAL) Claim Form

This is the form for submitting dental claims. The same input information is available from EMC transmissions. ACS Services will accept the 1994, 1999 (Version 2000), and the 2002 version of the ADA Dental Claim form.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper ADA Capture (CPI016)
Proc/Screen ID:	To Be Determined

ADA (DENTAL) Claim Form (CP-I-03)

Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City
6. State
7. Zip

PATIENT

8. Patient Name (Last, First, Middle)
9. Address
10. City
11. State
12. Date of Birth (MM/DD/YYYY) / /
13. Patient ID #
14. Sex ☐ M ☐ F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status ☐ Married ☐ Single ☐ Other
30. Sex ☐ M ☐ F
31. Is Patient covered by another plan ☐ No (Skip 32–37) ☐ Yes: ☐ Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex ☐ M ☐ F
36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity
43. Phone Number ( )
44. Provider ID #
45. Dentist Soc. Sec. or T.I.N.
46. Address
47. Dentist License #
48. First visit date of current series:
49. Place of treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
50. City
51. State
52. Zip Code
53. Radiographs or models enclosed? ☐ Yes, How many? _____ ☐ No
54. Is treatment for orthodontics? ☐ Yes ☐ No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes Brief description and dates
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither Brief description and dates

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City
65. State
66. Zip Code

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ADA (DENTAL) Claim Form (CP-I-03)

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

©American Dental Association, 2002
J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Provider ID #	Claim Billing Provider Identification Num-	DE2004

		ber	
2.1	Prior Authorization	Claims PA Number of Days Since	DE2499
2.2	Patient ID #	Enrollee Identification Number	DE3001
3	Carrier Name and Address	Claim Name and Address of Other Carrier (s)	DE2534
4	Patient name	Person Name	DE1001
5	Relationship to employee	Claim Patient's Relationship to Insured	DE2514
6	Sex		DE0000
7	Claim Adjustment Reason	Adjustment/Void Reason	DE2033
8	If Full Time Student School	Claim Related Document Number	DE2034
9	Employee/subscriber name and mail-ing address	Claim Other Insured's Name	DE2522
10	Employee/subscriber dental plan I.D. number	Claim Patient Account Number	DE2031
11	Employee/subscriber birthdate	Claim Other Insured's Date of Birth	DE2524
12	Employer (company) name and address	Claim Employer Name	DE2517
13	Group number	Claim Group Number or FECA Number (Insurance)	DE2516
14	Is patient covered by another dental plan	Claim COB Indicator	DE2544
14.1	Is Patient Covered By A Medical Plan?	Claim Dental Medical Coverage Flag	DE2684
15.1	Name and address of carrier(s)	Claim Name and Address of Other Carrier (s)	DE2534
15.2	Group no(s)	Claim Group Number or FECA Number (Insurance)	DE2516
16	Name and address of other employer (s)	Claim Name and Address of Other Carrier (s)	DE2534
17.1	Employee/subscriber name (if dif-ferent from patient's)	Claim Other Insured's Name	DE2522
17.2	Employer/subscriber dental plan .I.D number		DE0000
17.3	Employer/subscriber birthdate	Claim Other Insured's Date of Birth	DE2524
18	Relationship to patient	Claim Patient's Relationship to Insured	DE2514
19	Signed (patient signature)		DE0000
19.1	Date		DE0000
20	Signed (Employee/subscriber)		DE0000
20.1	Date		DE0000
21	Name of Billing Dentist or Dental Entity		DE0000

22	Address where payment should be remitted		DE0000
23	City, State, Zip		DE0000
24	Dentist Soc. Sec. or T.I.N.		DE0000
25	Dentist license no.		DE0000
26	Dentist phone no.		DE0000
27	First visit date (current series		DE0000
28	Place of treatment (Office, Hosp, ECF, Other)		DE0000
29	Radiographs or models enclosed? (No, Yes, How many)		DE0000
30	Is treatment result of occupational Illness or Injury? N/Y	Claim Employment Indicator	DE2074
31	Is treatment result of auto accident? N/Y	Claim Auto Accident	DE2431
32	Other accident? N/Y	Claim Other Accident Indicator	DE2028
33	If prosthesis, is this initial placement? N/Y		DE0000
34	Date of prior placement		DE0000
35	Is treatment for orthodontics? N/Y		DE0000
36	Identify missing teeth with 'X'		DE0000
37.1	Tooth # or letter	Claim Dental Tooth Code	DE2200
37.2	Surface	Claim Dental Surface Codes	DE2201
37.3	Description of service		DE0000
37.4	Date service performed	Claim Service From Date	DE2010
37.5	(Number of units)	Claim Number of Units/Visits/Studies	DE2009
37.6	Procedure number	Procedure Code	DE5002
37.7	Fee	Claim Billed Charge	DE2016
37.8	Third Party Payment	Claim Third Party Payment	DE2018
38	Remarks for unusual services	Claim Attachments Indicator	DE2030
40	Address Where Treatment Was Performed		DE0000
41	Total Fee Charged	Claim Total Document Charge	DE2017
42	Payment by other plan	Claim Third Party Payment	DE2018
43	ICN	Claim Request ICN	DE2001

Input Forms CP-I-04 TITLE XVIII (Medicare) Claim Form

This is the form for submitting Title XVIII (Medicare) Deductible and Coinsurance claims. The same input information is available through the EDI process.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper Crossover Capture (CPI018)
Proc/Screen ID:	To Be Determined

TITLE XVIII (Medicare) Claim Form (CP-I-04)

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Billing Provider Number	02 Last Name	03 First Name
04 Recipient ID Number	05 Patient's Account Number	06 Rendering Provider Number

1

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicaid ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NOC

2

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicaid ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NOC

3

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicaid ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NOC

4

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicaid ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NOC

25 Remarks

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

DMAS - 30 R 9/06

Field Definitions

#	Field Name	Data Element Name	Element

			ID
1	Transmission Code	Transmission Code	DE2476
2	Recipient Last Name		DE0000
2	Provider I.D. No.	Claim Billing Provider Identification Number	DE2004
3	Recipient First Name		DE0000
4	Recipient I. D. Number	Enrollee Identification Number	DE3001
5	Patient Account Number	Claim Patient Account Number	DE2031
6	Recipient's HIB Number (Medicare)	Claim Title18 Mcare Enrollee	DE2448
7	Primary Carrier Information Other Than (Medicare)	Claim COB Indicator	DE2544
8	Type Coverage (Medicare)	Claim Medicare Coverage Indicator	DE2402
9	Diagnosis	Diagnosis Code	DE5301
10	Place of Treat	Claim Professional Place of Service	DE2173
11	Accident/Emerg. Indicator (Acc)	Claim Accident Indicator	DE2027
11.1	Accident/Emerg. Indicator (Emer)	Claim Emergency Identifier	DE2802
11.2	Accident/Emerg. Indicator (Other)	Claim Other Accident Indicator	DE2028
12	Type Serv	Claim Type of Service	DE2072
13.1	Procedure Code	Procedure Code	DE5002
13.2	Procedure Code Modifier	Claims Procedure Code Modifier	DE2171
14	Visits/Units Studies	Claim Number of Units/Visits/Studies	DE2009
15	Date of Admission	Claim Admission Date	DE2105
16.1	Statement Covers Period: From	Claim Service From Date	DE2010
16.2	Statement Covers Period: Thru	Claim Service Thru Date	DE2011
17	Charges To Medicare	Claim Title XVIII Amount Billed to Medicare	DE2257
18	Allowed By Medicare	Claim Title XVIII Charge Allowed	DE2253
19	Paid By Medicare	Claim Title XVIII Medicare Paid Amount	DE2254
20	Deductible	Claim Title XVIII Deductible Amount	DE2251
21	Coinsurance	Claim Title XVIII Coinsurance Amount	DE2252
22	Paid By Carrier Other Than Medicare	Claim Third Party Payment	DE2018
24	NDC	Drug Code (NDC)	DE5200
25	Patient Pay Amount LTC Only	Claim Patient Pay Amount	DE2083
26	ICN	Claim Request ICN	DE2001
27	Signature		DE0000
28	Date		DE0000

Input Forms CP-I-05 TITLE XVIII (Medicare) Adjustment Form

This is the form for submitting Title XVIII (Medicare) Crossover Adjustments or Voids. The same input information is available through the EDI process.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper Crossover Capture (CPI018)
Proc/Screen ID:	To Be Determined

TITLE XVIII (Medicare) Adjustment Form (CP-I-05)

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092 VOID ☐ 094 | 2 BILLING PROVIDER NUMBER | A CN/REFERENCE NUMBER | B REASON | C INPUT CODE

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT'S I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RENDERING PROVIDER NUMBER

7 PRIMARY CARRIER INFO OTHER THAN MEDICARE ☐ 2 NO OTHER COV ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COV | 8 TYPE COV MEDICARE ☐ B | 9 DIAGNOSIS | 10 PLACE OF TREAT | 11 ACCIDENT/EMER INDICATOR ☐ ACC ☐ EMER ☐ OTHER | 12 TYPE SERV | 13 PROCEDURE CODE (5) | 14 RESTRICTED STUDIES (5) | 15 DATE OF ADMISSION MO. (2) DAY (2) YEAR (2) | 16 STATEMENT COVERS PERIOD FROM MO. (2) DAY (2) YEAR (2) THRU MO. (2) DAY (2) YEAR (2)

17 CHARGES TO MEDICARE | 18 ALLOWED BY MEDICARE | 19 PAID BY MEDICARE | 20 DEDUCTIBLE | 21 COINSURANCE | 22 PAID BY CARRIER OTHER THAN MEDICARE | 23 PATIENT PAY AMOUNT LTC ONLY

24 NDC

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

DMAS 31 R 5/06

Field Definitions

#	Field Name	Data Element Name	Element ID

1	Transmission Code	Transmission Code	DE2476
2	Provider I.D. No.	Claim Billing Provider Identification Number	DE2004
2.1	Reference Number	Claim Related Document Number	DE2034
2.2	Reason	Adjustment Reason Code	DE9877
2.3	Input Code	Claims Submission Identifier	DE2569
3.1	Recipient Last Name		DE0000
3.2	Recipient First Name		DE0000
4	Recipient I. D. Number	Enrollee Identification Number	DE3001
5	Patient Account Number	Claim Patient Account Number	DE2031
6	Recipient's HIB Number (Medicare)	Claim Title18 Mcare Enrollee	DE2448
7	Primary Carrier Information Other Than (Medicare)	Claim COB Indicator	DE2544
8	Type Coverage (Medicare)	Claim Medicare Coverage Indicator	DE2402
9	Diagnosis	Diagnosis Code	DE5301
10	Place of Treat	Claim Professional Place of Service	DE2173
11.1	Accident/Emerg. Indicator (Acc)	Claim Accident Indicator	DE2027
11.2	Accident/Emerg. Indicator (Emer)	Claim Emergency Identifier	DE2802
11.3	Accident/Emerg. Indicator (Other)	Claim Other Accident Indicator	DE2028
12	Type Serv	Claim Type of Service	DE2072
13.1	Procedure Code	Procedure Code	DE5002
13.2	Procedure Code Modifier	Claims Procedure Code Modifier	DE2171
14	Visits/Units Studies	Claim Number of Units/Visits/Studies	DE2009
15	Date of Admission	Claim Admission Date	DE2105
16.1	Statement Covers Period: From	Claim Service From Date	DE2010
16.2	Statement Covers Period: Thru	Claim Service Thru Date	DE2011
17	Charges To Medicare	Claim Title XVIII Amount Billed to Medicare	DE2257
18	Allowed By Medicare	Claim Title XVIII Charge Allowed	DE2253
19	Paid By Medicare	Claim Title XVIII Medicare Paid Amount	DE2254
20	Deductible	Claim Title XVIII Deductible Amount	DE2251
21	Coinsurance	Claim Title XVIII Coinsurance Amount	DE2252
22	Paid By Carrier Other Than Medicare	Claim Third Party Payment	DE2018
23	Patient Pay Amount LTC Only	Claim Patient Pay Amount	DE2083
24	NDC	Drug Code (NDC)	DE5200
25	ICN	Claim Request ICN	DE2001
26	Signature		DE0000
27	Date		DE0000

Input Forms CP-I-06 Pharmacy Claim Form

This is the form for submitting Pharmacy claims. The same input information is available through the EMC process.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper Pharmacy Capture (CPI026)
Proc/Screen ID:	To Be Determined

Pharmacy Claim Form (CP-I-06)

PLEASE PRINT CLEARLY

Provider Medicaid Number 01

Virginia Department of Medical Assistance Services

PHARMACY CLAIM FORM

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
1 02	03	04	05 / /	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14 / /	15	16 _ _ _ _ _ . _ _ _	17

Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
2 02	03	04	05 / /	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14 / /	15	16 _ _ _ _ _ . _ _ _	17

Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
3 02	03	04	05 / /	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14 / /	15	16 _ _ _ _ _ . _ _ _	17

Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
4 02	03	04	05 / /	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14 / /	15	16 _ _ _ _ _ . _ _ _	17

Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
5 02	03	04	05 / /	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14 / /	15	16 _ _ _ _ _ . _ _ _	17

Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Patient's Last Name, First Name	Patient's Medicaid Number	Sex	Birth Date	Level of Svc	Days Supply	Refill	DAW	Patient Loc
6 02	03	04	05 / /	06	07	08	09	10

Resubmission Code	Original Reference Number	Prescription Number	Date Dispensed	NDC Number	Metric Decimal Quantity	Unit Dose
11	12	13	14 / /	15	16 _ _ _ _ _ . _ _ _	17

Exempt	Prior Authorization Number	Prescriber's Number	Diagnosis	Amount Billed	COB	Payment by Primary Carrier
18	19	20	21	22 $	23	24 $

Provider Name, Address and Telephone Number

25

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative

26

Date (mm-dd-yy)

DMAS-173 [illegible]

(27) ICN

Field Definitions

#	Field Name	Data Element Name	Element ID

1	Provider Medicaid Number	Provider Identification Number	DE4002
2	Patient's Last Name, First Name	Claim Partial Recipient Name	DE2006
3	Patient's Medicaid Number	Enrollee Identification Number	DE3001
4	Sex	Enrollee Sex Code	DE3007
5	Birth Date	Enrollee Birth Date	DE3005
6	Level of Svc	Claim Pharmacy Level of Service	DE2229
7	Days Supply	Claim Pharmacy Days Supply	DE2216
8	Refill	Claim Pharmacy Refill Code	DE2212
9	DAW	Claim Dispensed as Written Indicator	DE2418
10	Patient Loc	Claim Pharmacy Patient Location Code	DE2228
11	Resubmission Code	Adjustment/Void Reason	DE2033
12	Original Reference Number	Claim Related Document Number	DE2034
13	Prescription Number	Claim Pharmacy Prescription Number	DE2211
14	Date Dispensed	Claim Service From Date	DE2010
15	NDC Number	Drug Code (NDC)	DE5200
16	Metric Decimal Quantity	Claim Number of Units/Visits/Studies	DE2009
17	Unit Dose	Drug Unit Dose Code	DE5042
18	Exempt	Claim Pharmacy PA/MC Code	DE2238
19	Prior Authorization Number	Prior Authorization Control Number	DE2024
20	Prescriber's Number	Claim Prescribing Physician Identification Number	DE2826
21	Diagnosis	Diagnosis Code	DE5301
22	Amount Billed	Claim Billed Charge	DE2016
23	COB	Claim COB Indicator	DE2544
24	Payment by Primary Carrier	Claim Third Party Payment	DE2018
25	Provider Name, Address and Telephone Number		DE0000
26	Signature of Provider or Representative		DE0000
26.1	Date		DE0000
27	ICN	Claim Request ICN	DE2001

Input Forms CP-I-07 Pharmacy (Compound Prescription) Claim Form

This is the form for submitting Pharmacy- Compound Prescription claims. The same input information is available through the EMC process.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	N/A
Estimated Volume:	N/A
Programs:	Paper Capture Driver (CPI010) Paper Pharmacy Capture (CPI026)
Proc/Screen ID:	To Be Determined

Pharmacy (Compound Prescription) Claim Form (CP-I-07)

PLEASE PRINT CLEARLY

Virginia Department of Medical Assistance Services

COMPOUND PRESCRIPTION

PHARMACY CLAIM FORM

Resubmission Code 01

Original Reference Number 02

Ind 03

Provider's Medicaid I.D. Number 04

Level of Service 05

Diagnosis 06

Exempt Indicator 07

Prior Authorization Number 08

PATIENT INFO: Medicaid I.D. Number 09

Last Name 10

First Name

Sex 11

Birth Date 12

Prescriber's Medicaid ID Number 13

Prescription Number 14

Date Dispensed 15 M M D D C C Y Y

Days Supply 16

Refill 17

Patient Location 18

DAW 19

Line	(20) NDC Number	(21) Description	(22) Metric Decimal Quantity
1			.
2			.
3			.
4			.
5			.
6			.
7			.
8			.
9			.
10			.
11			.
12			.
13			.

(23) COB Code

(24) Amount Paid by Primary Carrier $.

(25) Amount Billed include dispensing fee $.

(26) Comments:

Provider Name, Address and Telephone Number

27

This is to certify that the foregoing information is true, accurate and complete. I understand this payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative

28

DMAS-174 2/01

Date (mm-dd-oc-yy): 2 0

Field Definitions

#	Field Name	Data Element Name	Element ID

1	Resubmission Code	Adjustment/Void Reason	DE2033
2	Original Reference Number	Claim Related Document Number	DE2034
3	Ind	Claim Pharmacy Compound Indicator	DE2220
4	Provider's Medicaid ID Number	Provider Identification Number	DE4002
5	Level of Service	Claim Pharmacy Level of Service	DE2229
6	Diagnosis	Diagnosis Code	DE5301
7	Exempt Indicator	Claim Pharmacy PA/MC Code	DE2238
8	Prior Authorization Number	Prior Authorization Control Number	DE2024
9	Medicaid ID Number	Enrollee Identification Number	DE3001
10	Patient's Last Name	Enrollee Last Name	DE3110
10.1	First Name	Enrollee First Name	DE3111
11	Sex	Enrollee Sex Code	DE3007
12	Birth Date	Enrollee Birth Date	DE3005
13	Prescriber's Number	Claim Prescribing Physician Identification Number	DE2826
14	Prescription Number	Claim Pharmacy Prescription Number	DE2211
15	Date Dispensed	Claim Service From Date	DE2010
16	Days Supply	Claim Pharmacy Days Supply	DE2216
17	Refill	Claim Pharmacy Refill Code	DE2212
18	Patient Location	Claim Pharmacy Patient Location Code	DE2228
19	DAW	Claim Dispensed as Written Indicator	DE2418
20	NDC number	Drug Code (NDC)	DE5200
21	Description		DE0000
22	Metric Decimal Quantity	Claim Number of Units/Visits/Studies	DE2009
23	COB Code	Claim COB Indicator	DE2544
24	Amount Paid by Primary Carrier	Claim Third Party Payment	DE2018
25	Amount Billed	Claim Billed Charge	DE2016
26	Comments		DE0000
27	Provider Name, Address and Telephone Number		DE0000
28	Signature of Provider or Representative		DE0000
28.1	Date		DE0000
29	ICN	Claim Request ICN	DE2001

Input Forms CP-I-08 Prior Authorization Request Form

This is the form for submitting Prior Authorization requests.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	N/A
Proc/Screen ID:	To Be Determined

Prior Authorization Request Form (CP-I-08)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST

1 Original ☐ 2 Cancel ☐ 3 Change ☐

PAGE ____ OF ____

SERVICING PROVIDER INFORMATION

Number: 4
Name: 5
Address: 6
City: 7
State: 8 ZIP: 9
Contact Person: 10
Phone: 11

Enrollee ID# 12
Enrollee Name
Last 13
First 14
MI 15 Phone 16

Referring Provider # 17

18 ☐ Other Non-Paper Enclosure 19 ☐ X-Rays Enclosed 20 ☐ Photographs Enclosed

Diagnosis Code: 21 **PA Number:** 22 (If cancellation or change) **PA Service Type:** 23 (See codes on reverse side of form)

1 24 ☐ HCPCS/CPT 25 ☐ Revenue Code 26 Modifier # 27 Units Requested 28
Amount Requested: 29 $
Cost Per Unit: 30 $
Dates of Service Requested (MM/DD/CCYY) From 31 To 32
Line # (If Requesting Cancellation Or Change) 33

2 24 ☐ HCPCS/CPT 25 ☐ Revenue Code 26 Modifier # 27 Units Requested 28
Amount Requested: 29 $
Cost Per Unit: 30 $
Dates of Service Requested (MM/DD/CCYY) From 31 To 32
Line # (If Requesting Cancellation Or Change) 33

3 24 ☐ HCPCS/CPT 25 ☐ Revenue Code 26 Modifier # 27 Units Requested 28
Amount Requested: 29 $
Cost Per Unit: 30 $
Dates of Service Requested (MM/DD/CCYY) From 31 To 32
Line # (If Requesting Cancellation Or Change) 33

4 24 ☐ HCPCS/CPT 25 ☐ Revenue Code 26 Modifier # 27 Units Requested 28
Amount Requested: 29 $
Cost Per Unit: 30 $
Dates of Service Requested (MM/DD/CCYY) From 31 To 32
Line # (If Requesting Cancellation Or Change) 33

5 24 ☐ HCPCS/CPT 25 ☐ Revenue Code 26 Modifier # 27 Units Requested 28
Amount Requested: 29 $
Cost Per Unit: 30 $
Dates of Service Requested (MM/DD/CCYY) From 31 To 32
Line # (If Requesting Cancellation Or Change) 33

6 24 ☐ HCPCS/CPT 25 ☐ Revenue Code 26 Modifier # 27 Units Requested 28
Amount Requested: 29 $
Cost Per Unit: 30 $
Dates of Service Requested (MM/DD/CCYY) From 31 To 32
Line # (If Requesting Cancellation Or Change) 33

- **FOR ADDITIONAL PROCEDURES FOR THE SAME PA#, USE AN ADDITIONAL FORM – ENTER BOXES 4, 5, 12, 13, 14, AND 15 ON EACH ADDITIONAL FORM**

34 **Provider Signature** _____ 35 **Date Signed** _____

Field Definitions

#	Field Name	Data Element Name	Element ID

1	Original	PA Incoming Request Code	DE2886
2	Cancel	PA Incoming Request Code	DE2886
3	Change	PA Incoming Request Code	DE2886
4	Provider Number	National Provider Identifier	DE4700
5	Provider Name	Provider Name	DE4085
6	Provider Address	Provider Address Line	DE4097
7	Provider City	Provider Address City Name	DE4130
8	Provider State	Provider Address State	DE4098
9	Provider Zip Code	Provider Address ZIP Code	DE4099
10	Provider Contact Person	Provider Contact Name	DE4201
11	Provider Phone Number	Provider Phone Number	DE4090
12	Enrollee Identification Number	Enrollee Identification Number	DE3001
13	Enrollee Name	Enrollee Last Name	DE3110
14	Enrollee First Name	Enrollee First Name	DE3111
15	Enrollee Middle Initial	Enrollee Middle Initial	DE3112
16	Enrollee Phone Number	Enrollee Telephone Number	DE3095
17	Referring Provider Number	PA Referring Provider Identification Number	DE2652
18	Other Non-paper Enclosure Indicator	PA Non-paper Enclosure Indicator	DE2643
19	Enclosed X-Rays Indicator	PA X-rays Enclosed Indicator	DE2644
20	Enclosed Photographs Indicator	PA Photographs Enclosed Indicator	DE2645
21	Diagnosis Code	Diagnosis Code	DE5301
22	Prior Authorization Number (If cancellation or change)	Prior Authorization Control Number	DE2024
23	PA Service Type	PA Service Type Code	DE2635
24	HCPCS/CPT	Procedure Code Type	DE5001
25	Revenue Code Indicator	Procedure Code Type	DE5001
26	(PA Procedure Code)	Procedure Code	DE5002
27	Modifier #	Claims Procedure Code Modifier	DE2171
28	Units Requested	PA Requested Units	DE2612
29	Amount Requested	PA Requested Amount	DE2615
30	Cost Per Unit	PA Actual Cost Per Unit	DE2646
31	From Date of Service	PA Request From Date	DE2608
32	To date of Service	PA Request Through Date	DE2609
33	Prior Authorization Line Number (If requesting cancellation)	PA Line Number	DE2607
34	Provider Signature		DE0000
35	Date Signed		DE0000

Input Forms CP-I-09 Prior Review and Authorization Request - Supporting Documentation

This is the form for submitting Prior Authorization supporting documentation.

Subsystem:	Claims
Source/Originator:	Providers
Frequency:	Daily
Estimated Volume:	N/A
Programs:	N/A
Proc/Screen ID:	To Be Determined

Prior Review and Authorization Request - Supporting Documentation (CP-I-09)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND
AUTHORIZATION REQUEST
SUPPORTING DOCUMENTATION

1 ☐ Return Pend Documentation
2 ☐ Request for Reconsideration
(Check only (1) box)

Pending or Denied PA #
3 _____

4 Check appropriate box(es)

Line 1 ☐	Line 2 ☐	Line 3 ☐	Line 4 ☐	Line 5 ☐
Line 6 ☐	Line 7 ☐	Line 8 ☐	Line 9 ☐	Line 10 ☐
Line 11 ☐	Line 12 ☐	Line 13 ☐	Line 14 ☐	Line 15 ☐
Line 16 ☐	Line 17 ☐	Line 18 ☐		

Provider Information

Provider Number
5 _____

Enrollee Number
11 _____

Name 6 _____
Address 7 _____
City 8 _____ State 9 _____
Zip 10 _____ - _____

Enrollee Name
Last 12 _____ First 13 _____ MI 14 _____

15 ☐ Other Non-Paper Enclosure 17 ☐ Photographs Enclosed
16 ☐ X-Rays Enclosed 18 ☐ Dental Models Enclosed

PA Service Type: 19 _____
(See codes on reverse side of form)

20 **COMMENTS:** _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

21 **Provider Signature** _____ 22 **Date Signed** _____

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Field Definitions

#	Field Name	Data Element Name	Element ID

1	Return Pend Documentation	PA Incoming Request Code	DE2886
2	Request for Reconsideration	PA Incoming Request Code	DE2886
3	Pending or Denied PA#	Prior Authorization Control Number	DE2024
4	Line Item(s) Indicator	PA Line Number	DE2607
5	Provider Number	National Provider Identifier	DE4700
6	Provider Name	Provider Name	DE4085
7	Provider Address	Provider Address Line	DE4097
8	Provider City	Provider Address City Name	DE4130
9	Provider State	Provider Address State	DE4098
10	Provider Zip Code	Provider Address ZIP Code	DE4099
11	Enrollee Number	PA Enrollee Identification Number	DE2650
12	Enrollee Last name	Enrollee Last Name	DE3110
13	Enrollee First Name	Enrollee First Name	DE3111
14	Enrollee Middle Initial	Enrollee Middle Initial	DE3112
15	Other Non-paper Enclosure Indicator	PA Non-paper Enclosure Indicator	DE2643
16	Enclosed X-Rays Indicator	PA X-rays Enclosed Indicator	DE2644
17	Enclosed Photographs Indicator	PA Photographs Enclosed Indicator	DE2645
18	Enclosed Dental Models Indicator	PA Dental Models Enclosed Indicator	DE2700
19	PA Service Type	PA Service Type Code	DE2635
20	Comments	PA Comments Text	DE2619
21	Provider Signature		DE0000
22	Date Signed		DE0000

Input Forms CPRXXX XXX

This process reads the monthly Claims Extract and creates the IRP files for loading to the IRP.

Subsystem:	Claims
Source/Originator:	
Frequency:	Monthly
Estimated Volume:	
Programs:	N/A
Proc/Screen ID:	To Be Determined
Graphics:	N/A

Field Definitions

#	Field Name	Data Element Name	Element ID
N/A			