



# Commonwealth of Virginia Fiscal Agent and Provider Enrollment Services Claims Services Data Entry & Claims Resolution Operational Procedure Manual

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# 1 Introduction

## 1.1 Purpose

████████████████████. (██████) is the fiscal agent for the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) and serves as a liaison between DMAS and the provider community. ██████ Data Entry and Claims Resolution Units are responsible for:

- Data capture of payment requests
- Adjustment and Void processing
- Exception Claims Processing (Claims Resolution)

This manual will provide the detailed steps for performing the above requirements.

## 1.2 Department Overview

### 1.2.1 Objectives and Tasks

Claims Services includes Data Entry and Claims Resolution. The primary objectives for Data Entry and Claims Resolution is to ensure the accurate and efficient processing of payment documents. The processing of paper documents includes entering paper payment documents into the MMIS system for adjudication, resolving pended claims and adjusting and voiding payments to correct paid payments..

**Department task include:**

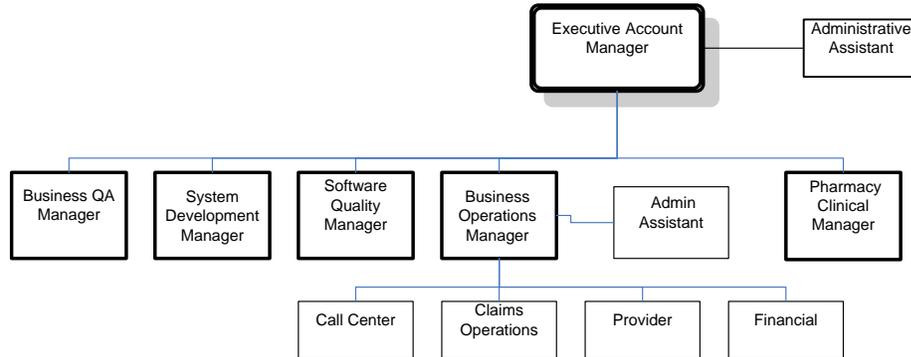
- Capturing required data elements, perfecting the data captured and correcting failed edits to ensure the accurate processing and adjudication of all paper Medicaid payment request.
- Resolving pended payment request suspended for validity edits and history audits within required mainframes
- Coordinating with DMAS as appropriate for processing of all Medicaid payment requests.

In addition, there are quality initiatives in place to monitor the correct processing of payment requests and to correct issues that arise in the course of daily operations. Some of these quality initiatives include sampling of payment requests on a consistent basis to ensure proper entry and processing, as well as re-training.

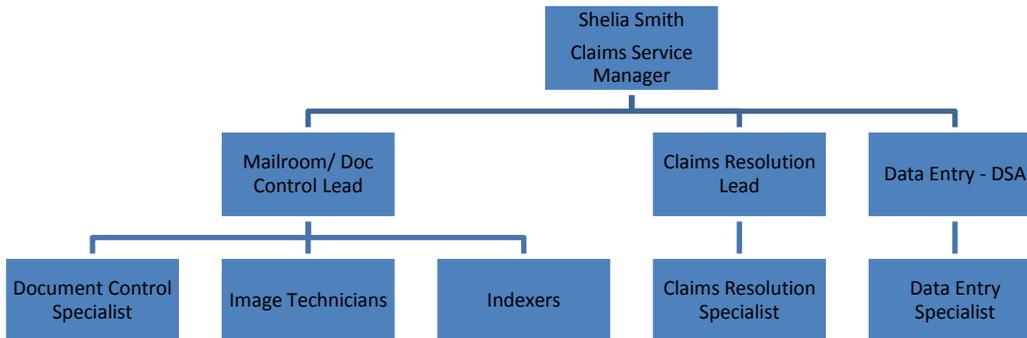
## 1.2.2 Staffing Overview

The Claims Services Operations Unit consists of Data Entry Specialists, Claims Resolution Specialists, Claims Resolution Lead and Claims Services Manager. The Claims Services Manager is responsible for overseeing the daily operations of the Units and reports to the Business Operations Manager. Below is the organizational chart for Claims Services followed by descriptions for the Data Entry and Claims Resolution positions:

### VA MMIS FAS and PES Organization Chart



### Claims Services Organization Chart



#### 1.2.2.1 Claims Services Operations Manager

The Claim Services Manager is responsible for the functions performed in the Data Entry and Claims Resolution Units. The Claims Services Manager is responsible for the day to day management of the front line staff, volumes, quality of services delivered and the performance of the Units in accordance with contractual service levels. Additional core responsibilities include:

- Performing side-by-side performance observations on a regular basis for all direct reports to measure quality and efficiency of work performed.
- Creating work plans, procedure manuals, and other required materials to ensure department objectives are met.

- Providing support to staff for questions and handles escalated situations quickly and efficiently.
- Meeting with Managers of other functional areas to understand the effectiveness of staff in delivering the support services for their areas of responsibility.
- Developing staff through daily interactions, coaching and on-going performance evaluations.
- Monitoring daily, weekly and monthly performance levels. Leverages business intelligence to actively contribute to trending and root cause analysis efforts.
- Educating staff on department procedures and builds subject matter expert (SME) level knowledge for each job function.
- Responsible for in-depth knowledge of the tools and services that support their Units: Datacap Software, FileNet Enterprise Content Management (ECM) System, FileNet Workflow, MMIS, etc.

### **1.2.2.2 Data Entry Specialist**

The Data Entry Specialists are responsible for perfecting data captured through optical character recognition (OCR), intelligent character recognition (ICR) and manual entry from image, and perform verification of data validation failures.

- Manually enters data from claims before system performs validations and business rules editing.
- Verifies data flagged by the system for validation and business rules failures.
- Manually enters data from Assessments and Turnaround Documents directly into the MMIS.
- Escalates required situations appropriately and in accordance to department procedures.
- Notifies management of system issues or other trends identified.
- Manages adherence to scheduled hours, quality, efficiency of work, and on-going knowledge development.

### **1.2.2.3 Claims Resolution Specialist**

The Claims Resolution Specialist is responsible for resolving pended claims according to DMAS-approved resolution parameters. The Claims Resolution Specialist:

- Researches and resolves claims pended for possible duplicate.
- Reviews claim pends that failed MMIS validity edits and history audits and resolves using predefined resolution instructions.
- Reviews and researches paid transactions for adjustment or void.
- Escalates required situations appropriately and in accordance to department procedures.
- Notifies management of system issues or other trends identified.
- Manages adherence to scheduled hours, quality, efficiency of work, and on-going knowledge development.

## 1.3 Service Level Requirements

Service Level Agreements – Data Entry and Claims Resolution	
Description	Performance Target
Receive, control, assign a unique ICN, image, and transfer to MMIS and adjudicate all paper payment requests and their attachments or any other associated claims documents.	Process paper payment requests from receipt through adjudication in 72 hours.
Perform on-line data entry of Pre-admission Screening Plan DMAS-96 forms, Uniform Assessment Instrument (UAI) forms and the Medicaid Waiver Services Pre-screening Plan of Care (DMAS 113-B), Maternal Care Coordination Record (DMAS 50), and Infant Care Coordination Record (DMAS 51) to MMIS system.	< 5 working days from receipt
Perform on-line data entry of Pre-admission Screening Plan DMAS-96 forms, Uniform Assessment Instrument (UAI) forms and the Medicaid Waiver Services Pre-screening Plan of Care (DMAS 113-B), Maternal Care Coordination Record (DMAS 50), and Infant Care Coordination Record (DMAS 51) to MMIS system.	100% accuracy
Perform on-line entry of payment requests to include comprehensive data capture edits which will ensure the accuracy of captured data.	99.997% accuracy
Perform on-line entry of assessment TADs.	≤ 5 working days from receipt
All payment request transactions suspended to the contractor location for any reason must be paid or denied.	≤ 30 days from original pend date

# 2 Data Entry Procedures

## 2.1 Assessments

Assessment Forms include Long-Term Care Service Authorization Form (DMAS-96) and Uniform Assessment Instrument Form (UAI Part A and UAI Part B). Other forms that might be included are the Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions (DMAS-95). The Assessment packet data is keyed directly in MMIS online screens.

Note that forms are keyed even if some data fields are missing or obviously incorrect. The system will “pend” incomplete records and generate a Turnaround Document (TAD) cover letter to the provider requesting correction of data that is in error.

These forms can be found in the Appendix: DMAS-96 , UAI Section, DMAS-95, and TAD.

Note:

1. Effective 12/17/15, [REDACTED] will only accept paper Hospital UAIs sent in with a Physician’s Signature Date after 11/30/15. All others UAIs are to be sent to DMAS.
2. Effective July 1, 2012, [REDACTED] will discontinue processing Assessments for AIDS Waiver with dates of service on or after July 1, 2012. HIV Assessments should be rejected and sent to Melissa Fritzman. These Assessments can be identified with a code of 3 in the Medicaid Authorization block on the DMAS-96 form.

Any Assessments with a service date prior to July 1 should be processed as usual.

3. [REDACTED] will also discontinue processing any Assisted Living Assessment or Reassessment forms that have dates of service/reassessment dates on or after 7/1/12 with a provider number that begins with 00874.

### **DMAS-96**

If the MEDICAID AUTHORIZATION block on this form is coded with either 11 or 12, check the service date and both blocks of the provider number to determine if the assessment should be processed or rejected.

### **Eligibility Communication Document**

If the Residential Living or the Assisted Living box is checked, check the reassessment date and the provider number to determine if the reassessment should be processed or rejected.

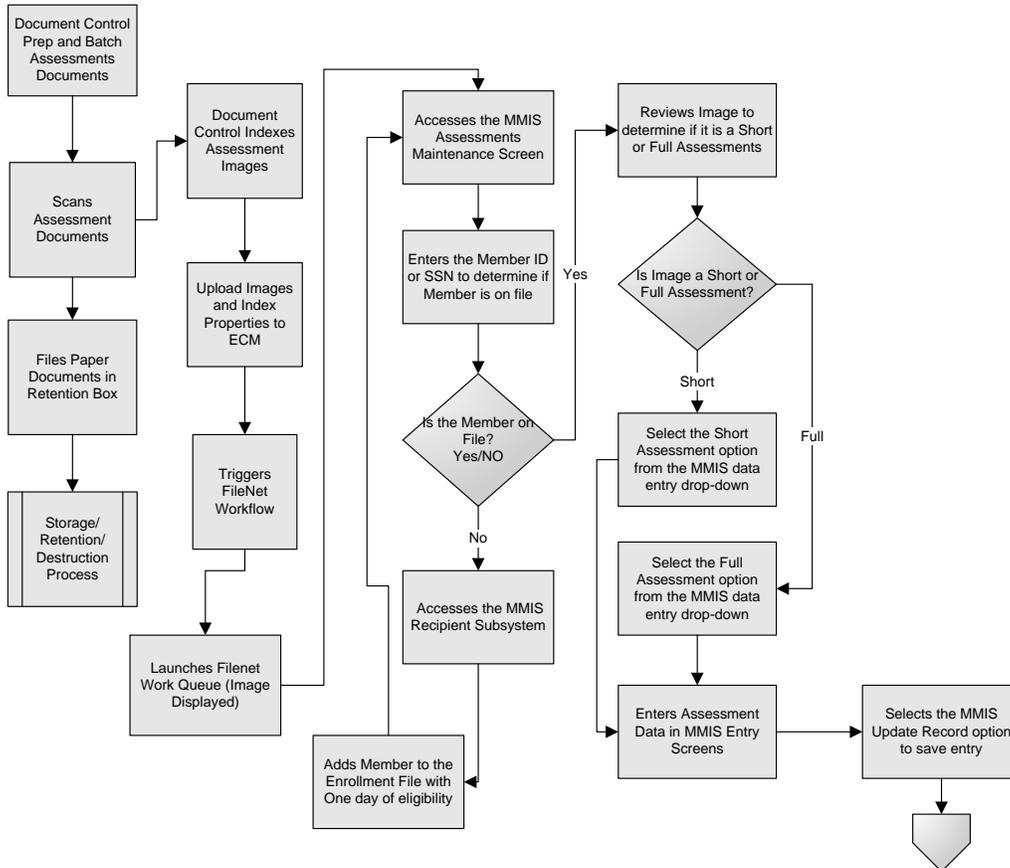
Rejected Assisted Living /Reassessment forms should be returned to the assessor unprocessed.

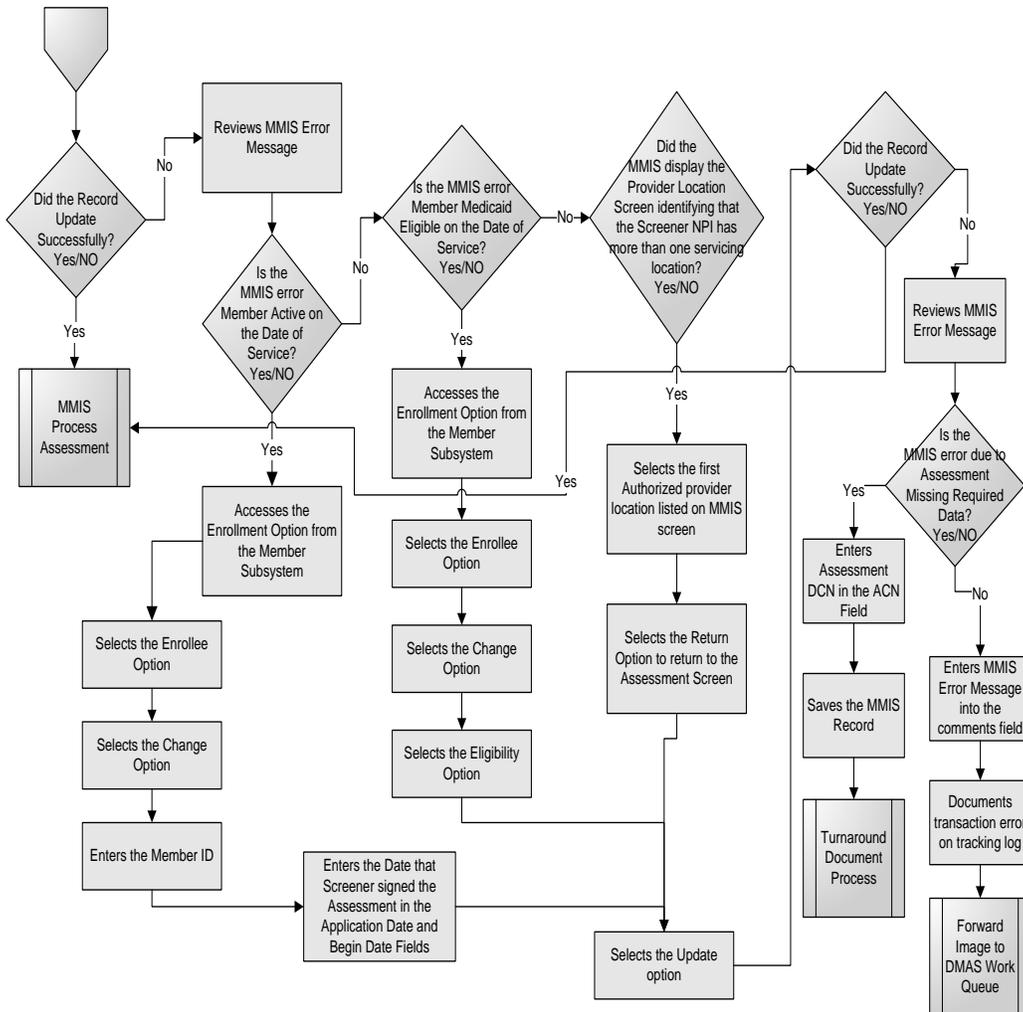
**Note:**

The rules for the Assisted Living/Reassessment forms apply if they come in as individual documents (DMAS-96), (Eligibility Communication Document) or both documents together (DMAS-96 and Eligibility Communication Document).

## 2.2 Assessments Process Workflow

This diagram presents a graphic depiction of the document preparation, scanning, and data capture processes.





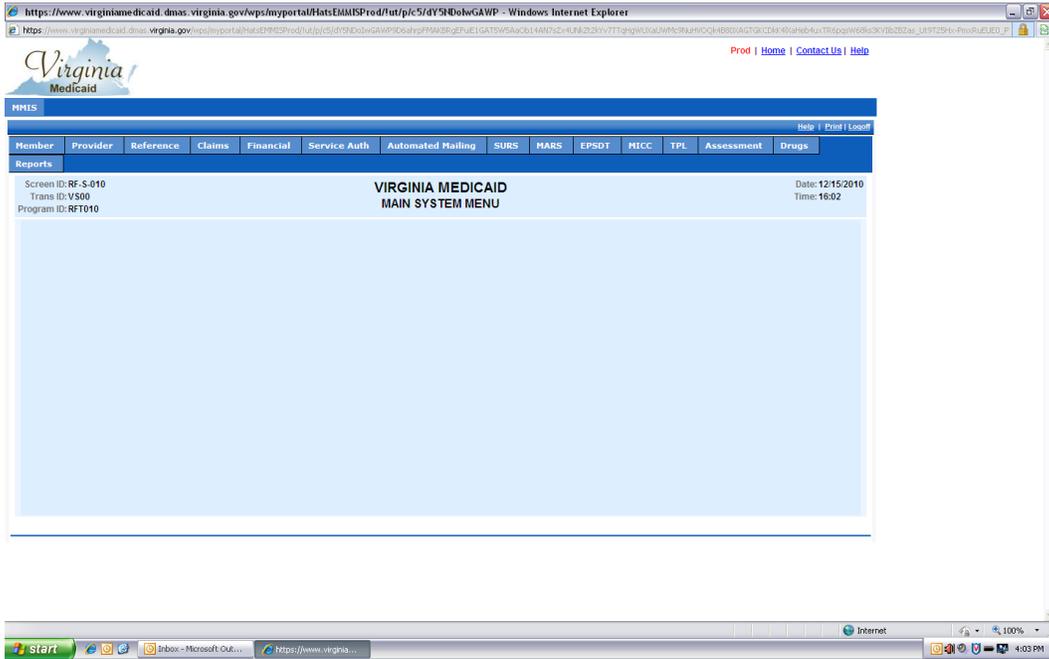
## 2.2.1 DMAS-96, Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Forms

**🕒 SLA (Service Level Agreement): Process Assessments < 5 working days from receipt with data entry accuracy of 100%**

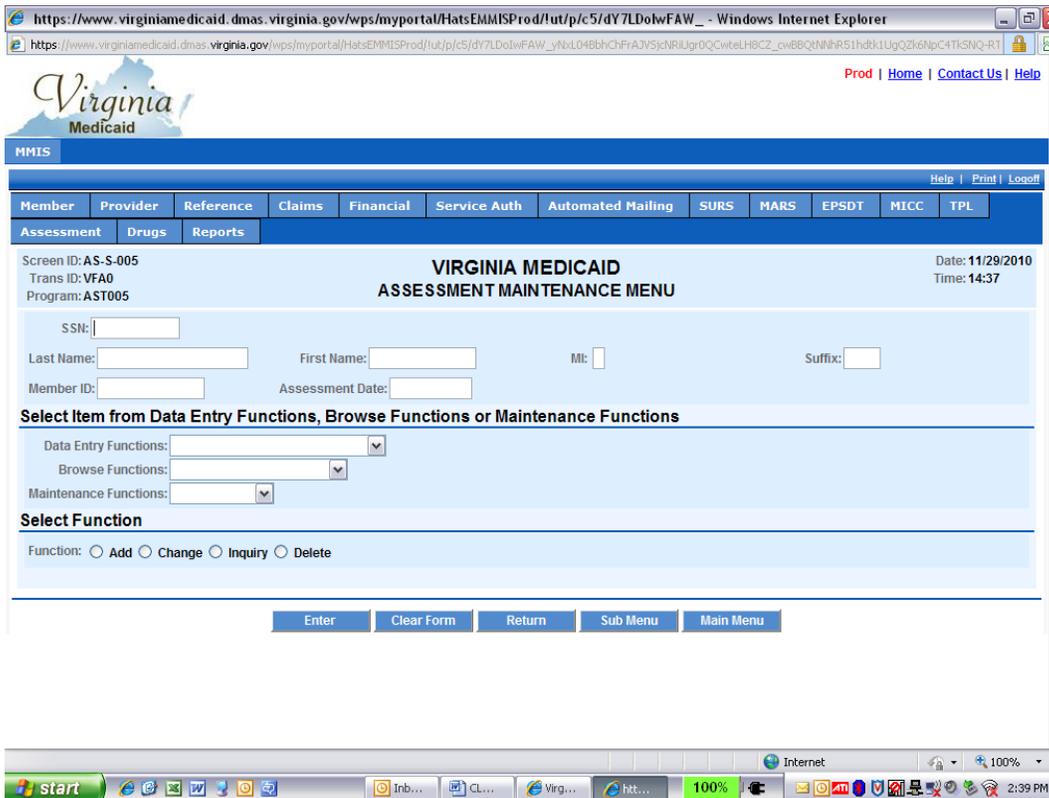
### Procedure:

1. From the Main System menu, select the Assessments Subsystem icon to display the Assessment Maintenance Menu screen.

(RF-S-010)



(screen AS-S-005)



2. On the Assessment Maintenance Menu

- Enter the SSN or Member ID from the assessment form.
  - Enter the Assessment date without slashes: ex 08182010.
3. Select “Short Assessment or ACRR” from the Data Entry Functions drop-down box.
  4. Click the “Add” radio button to select the task function, and then Click on the “Enter” button to display the “Short Assessment or ACRR” Page 1 screen.
    - If the MMIS error message “Member Not Active on Date of Screening” displays, go to “adding Member to Enrollment File” procedures found in Section 2.2.5
    - If the MMIS error message “Member on File but not Eligible on Date of Screening”, go to “Adding New Eligibility Segment for Canceled Member” procedures found in Section 2.2.6.
    - If the MMIS error message “Not Medicaid Eligible” or Not Medicaid Eligible on the Day of Screening”, go to “Changing a Member Record” procedures found in Section 2.2.7.

**(Screen AS-S-015)**

The screenshot displays the Virginia Medicaid MMIS system interface. The browser address bar shows the URL: https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/HatsEMMISProd/tut/p/c5/dY7bDKNAFEW\_. The page title is "SHORT ASSESSMENT OR ACRR PAGE 1 - ADD". The form includes the following sections and fields:

- Screen Information:** Screen ID: AS-S-015, Trans ID: VFC3, Program ID: AST015. Date: 11/29/2010, Time: 16:39.
- Assessment Control Number:** [Text Field]
- SSN:** [Text Field]
- Last Name:** [Text Field]
- Member ID:** [Text Field]
- Address:** [Text Field] (Current address: ORANGE VA 22960 1542)
- Reassessment:** [Text Field]
- Source Code:** [Text Field]
- First Name:** [Text Field]
- FIPS:** [Text Field]
- MI:** [Text Field]
- Assessment Status:** [Text Field]
- Assessment Date:** [Text Field]
- Suffix:** [Text Field]
- DMAS-96 and DMAS-95 MIMR Supplemental:**
  - Medicaid Eligibility: [Text Field]
  - Medicaid Application: [Text Field]
  - Auxiliary Grant: [Text Field]
  - Medicaid Authorization: [Text Field]
  - Target Case Management: [Text Field]
  - Service Availability: [Text Field]
  - Length of Stay: [Text Field]
  - Level I SCR 1: [Text Field]
  - Level I SCR 2: [Text Field]
  - Level II Assessment: [Text Field]
  - Level II SCR: [Text Field]
  - Physician Auth Date: [Text Field]
  - Level II MI: [Text Field]
  - Dual Diagnosis: [Text Field]
  - Level II M/R: [Text Field]
- UAI - Demographics:**
  - DOB: 08/12/1964
  - Race: 2
  - Gender: F
  - Marital Status: U
  - Communication of Needs: [Text Field]
- UAI - Physical Environment:**
  - Residence: [Text Field]

Navigation buttons at the bottom include: Enter, Update, Clear Form, Refresh, Name Search, Prov Loc, LOC, Del Seg, Return, Sub Menu, Main Menu, Cur Seg, Next.

5. Key assessment information in entry screen fields using the DMAS-96, Adult Care Residence Eligibility Communications and Uniform Assessment Instrument (UAI)- Short Assessment Keying Instructions.
  - **If keying from the “Adult Care Residence Eligibility Communication Document” (Reassessment), key only those fields that are preceded by an asterisk. This applies only to Authorization Level 11**
  - If keying fields have multiple answers, leave blank and proceed keying

6. Verify data entered then click the “Enter” button to display the Short “Assessment OR ACRR” Page 2 screen.

(Screen AS-S-020)

The screenshot displays the Virginia Medicaid MMS portal interface. At the top, there is a navigation bar with the Virginia Medicaid logo and a menu with options like 'Home', 'Contact Us', and 'Help'. Below this is a header section with 'MMS' and a 'Help | Print | Logout' link. A main navigation bar contains tabs for 'Member', 'Provider', 'Reference', 'Claims', 'Financial', 'Service Auth', 'Automated Mailing', 'SUBS', 'MARS', 'EPSDT', 'MCC', 'TPL', 'Assessment', and 'Drugs'. The 'Assessment' tab is selected, and a 'Reports' dropdown is visible. The main content area shows the 'SHORT ASSESSMENT OR ACRR PAGE 2-ADD' form. The form includes the following information:

- Screen ID: AS-S-020
- Trans ID: VFC3
- Program ID: AST015
- Assessment Control Number: 24689
- Reassessment: N
- Source Code: ACRS
- Assessment Status: 11/17/2010
- Assessment Date: 11/17/2010
- Time: 10:41

The form is divided into three main sections, each with a set of checkboxes:

- UAI - Functional Status:** Includes checkboxes for Bathing, Dressing, Toileting, Transferring, Eating/Feeding, Bowel, Bladder, Walking, Wheeling, Stairclimbing, Mobility, Meal Preparation, Housekeeping, Laundry, Money Management, Transportation, Shopping, and Using Phone.
- UAI - Physical Health Assessment:** Includes checkboxes for Hospital, Nursing Facility, Adult Residence, Living Will, Durable Power, Other, Total Medicine, and Take Medicine.
- UAI - Psycho-Social Assessment:** Includes checkboxes for Orientation, Short Term, Long Term, Judgement, and Behavior Pattern.

At the bottom of the form, there is a row of buttons: 'Enter', 'Clear Form', 'Refresh', 'Previous', 'Return', 'Sub Menu', and 'Main Menu'. The browser's address bar shows the URL: https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/HatsEMMSProd/tut/p/c5/dy7dEkJQGEUF - Windows Internet Explorer.

7. After keying Assessment information on page 2, click “Enter”

- a. **Error Message**

- If a error message is displayed at the bottom of the screen, EX: Stair Climbing Code is invalid or missing,
- Verify error message
- Click “Previous” button to advance the screen back to page 1
- Click “Update”
- The message “Errors Found: Choose Update Again to Confirm” is displayed
- Click “Update”
- Assessment Status will say “Pended”
- Click “Sub Menu” at the bottom of the screen or “Assessment” at the top right of the screen to continue keying next Assessment

- b. **No Errors Found**

- If no errors are found the message “No Errors Found, Choose Update To Accept” is displayed
- Click “Update”
- Assessment Status will say “Approved”
- Click “Sub Menu” at the bottom of the screen or “Assessment” at the top right of the screen to continue keying next Assessment

## 2.2.2 DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI)–Short Assessment Form Keying Instructions

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
*Assessment Control Number	Assessment Control Number	Key ACN from back of first page
Social Security or Member ID	SSN or Member ID	Auto Populated
*Residential Living	Reassessment	<b>Key “Y”</b> if keying from the “Adult Care Residence Eligibility Communication Document”(Reassessment) which applies only to Authorization Level 11. <b>If the Reassessment form is not present, key “N”</b>
Last Name	Last Name	Auto Populated unless enrollement is needed
First Name	First Name	Auto Populated unless enrollement is needed
Not on form	MI	
Not on Form	Suffix	
Medicaid ID	Member ID	Auto Populated unless enrollement is needed
Is the Individual Currently Medicaid Eligible?	Medicaid Eligibility	If marked on assessment form, enter the numeric value  Yes = <b>1</b>  Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission OR within 45 days of application or when personal care begins = <b>2</b>  Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission = <b>3</b>
If no, has Individual formally applied for Medicaid?	Medicaid Application	Always enter “Y”
Is Individual currently Auxiliary Grant eligible?	Auxiliary Grant	If marked on assessment form, enter the alpha value of “Y” or “N” If blank, tab to next field

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
Level of Care	Medicaid Authorization	<p>If marked on assessment form, enter the numeric value ALF Residential Living = 11</p> <p>Note: Authorization type “11” is the only valid value for Short Assessments. <b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment) this field is automatically populated</b></p>
*Targeted Case Management for ALF	Target Case Management	<p>If marked on assessment form, enter the numeric value of “N” or “Y” If blank, tab to next field</p> <p><b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment), always key “N”</b></p>
Service Availability	Service Availability	<p>If marked on assessment form, enter the numeric value</p> <p>Client on waiting list for service authorized = 1 Desired service provider not available = 2 Service provider available, care to start immediately = 3 If blank, key in default value of “9”</p>
Length of Stay	Length of Stay	<p>If marked on assessment form, enter the numeric value Temporary (less than 3 months) = 1 Temporary (less than 6 months) = 2 Continuing (more than 6 months) = 3 If blank, key in default value of “8”</p>
i*Level I/AFL Screening Identification (Line 1)	Level I SCR 1	<p>Enter the first 10-digit NPI located on Line 1</p> <p>If blank, invalid or not eligible, return to DMAS. Invalid and not eligible documents will be returned with a screen print indicating the error message. Blank documents will not have a screen print attached..</p>
Did the individual expire after the	Patient Expired	<p>If marked on assessment form, enter the alpha value of “Y” or “N”.</p>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
PAS/ALF Screening decision but before services were received		If blank, leave blank and tab to next field
<u>*Level I Physician</u>	<u>Physician Authorization Date</u>	<p>Enter the “Date” signed by Level I Physician.</p> <p><u>Must Be MMDDYYYY format.</u></p> <p>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment), key the Reassessment date.</p>
Uniform Assessment Instrument Form Part A - Demographics		
*Communication of Needs	Com of Needs	<p>Enter numeric value</p> <p>Verbally, English = 0</p> <p>Verbally, Other Language = 1</p> <p>Sign Language/Gestures/Device = 2</p> <p>Does Not Communicate = 3</p> <p>If no numeric value is coded, leave blank</p>
*Where do you live? Does anyone live with you?	Residence	<p>Always key from left to right to enter (2) digit numeric value</p> <p>House/Own and Alone = 01</p> <p>House/Rent and Alone = 11</p> <p>House/Other and Alone = 21</p> <p>Apartment and Alone = 31</p> <p>Rented Room and Alone = 41</p> <p>House/Own and Spouse = 02</p> <p>House/Rent and Spouse = 12</p> <p>House/Other and Spouse = 22</p> <p>Apartment and Spouse = 32</p> <p>Rented Room and Spouse = 42</p> <p>House/ Own and Other = 03</p> <p>House/Rent and Other = 13</p> <p>House/ Other and Other = 23</p> <p>Apartment and Other = 33</p> <p>Rented Room and Other = 43</p> <p>Adult Care Residence = 50</p> <p>Adult Foster = 60</p> <p>Nursing Facility = 70</p> <p>Mental Health/Retardation Facility = 80</p> <p>Other = 90</p>

Uniform Assessment Instrument Part A – Functional Status		
*Bathing	Bathing	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field, If “No” marked enter value “00”</p> <p>MH Only/Mechanical Help = 10            HH Only/Human Help and Supervision = 21            HH Only/Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Performed by Others = 40</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Dressing	Dressing	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p> <p>MH Only/Mechanical Help = 10            HH Only/Human Help and Supervision = 21            HH Only/Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Performed by Others = 40            Is Not Performed = 50</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Toileting	Toileting	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p> <p>MH Only /Mechanical Help = 10            HH Only/Human Help and Supervision = 21            HH Only/Human Help and Physical</p>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
		<p>Assistance = 22  MH &amp; HH and Supervision = 31  MH &amp; HH and Physical Assistance = 32  Performed by Others = 40  Is Not Performed = 50  If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Transferring	Transferring	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help” field. If “No” marked enter value “00”  MH Only / Mechanical Help = 10  HH Only / Human Help and Supervision = 21  HH Only / Human Help and Physical Assistance = 22  MH &amp; HH and Supervision = 31  MH &amp; HH and Physical Assistance = 32  Performed by Others = 40  Is Not Performed = 50  If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Eating/Feeding	Eating/Feeding	<p>If marked on Assessment form, enter the numeric value</p> <p>Review the “Need Help?” field. If “No” marked enter value “00”.</p> <p>MH Only/Mechanical Help= 10  HH Only/Human Help and Supervision= 21  HH Only/Human Help and Physical Assistance= 22  MH &amp; HH and Supervision= 31  MH &amp; HH and Physical Assistance= 32</p>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
		<p>Performed by Others and Spoon Fed= 41            Performed by Others and Syringe/Tube Fed= 42            Performed by Others and Fed by IV= 43</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Bowel	Bowel	<p>If marked on assessment form, Enter the Numeric Value            No = 0            Yes = 1, 2, 3 or 6</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “0”.</p>
*Bladder	Bladder	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p> <p>Incontinent - Less then weekly = 1            External Device/Indwelling/Ostomy - Self Care = 2            Incontinent – Weekly or More = 3            External Device – Not Self Care = 4            Indwelling Catheter - Not Self Care = 5            Ostomy – Not Self Care = 6</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “0”.</p>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
*Walking	Walking	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help” field. If “No” marked enter value “00”</p> <p>MH Only / Mechanical Help = 10            HH Only / Human Help and Supervision = 21            HH Only / Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Is Not Performed = 50</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Wheeling	Wheeling	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p> <p>MH Only / Mechanical Help = 10            HH Only / Human Help and Supervision = 21            HH Only / Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Performed by Others = 40            Is Not Performed = 50</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Stairclimbing	Stairclimbing	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
		<p>MH Only / Mechanical Help = 10            HH Only / Human Help and Supervision = 21            HH Only / Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Is Not Performed = 50</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Mobility	Mobility	<p>If marked on assessment form, enter the numeric value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p> <p>MH Only / Mechanical Help = 10            HH Only / Human Help and Supervision = 21            HH Only / Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Confined / Moves About = 40            Confined / Does Not Move About = 50</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Meal Preparation	Meal Preparation	<p>If marked on assessment form, enter the alpha value of “Y or “N”</p> <p>If blank, leave blank and tab to next field</p>
*Housekeeping	Housekeeping	<p>If marked on assessment form, enter the alpha value of “Y or “N”</p> <p>If blank, leave blank and tab to next field</p>
*Laundry	Laundry	<p>If marked on assessment form, enter the alpha value of “Y or “N”</p>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
		If blank, leave blank and tab to next field
*Money Mgmt	Money Management	If marked on assessment form, enter the alpha value of “Y or “N” If blank, leave blank and tab to next field
*Transportation	Transportation	If marked on assessment form, enter the alpha value of “Y or “N” If blank, leave blank and tab to next field
*Shopping	Shopping	If marked on assessment form, enter the alpha value of “Y or “N” If blank, leave blank and tab to next field
*Using Phone	Using Phone	If marked on assessment form, enter the alpha value of “Y or “N” If blank, leave blank and tab to next field
*Home Maintenance	Home Maintenance	If marked on assessment form, enter the alpha value of “Y or “N” If blank, leave blank and tab to next field
Uniform Assessment Instrument Part B – Physical Health Assessment		
Hospital	Hospital	If marked on assessment form, enter the alpha value of “N” or “Y” If blank, leave blank and tab to next field
Nursing Facility	Nursing Facility	If marked on assessment form, enter the alpha value of “N” or “Y” If blank, leave blank and tab to next field
Adult Care Residence	Adult Residence	If marked on assessment form, enter the alpha value of “N” or “Y” If blank, leave blank and tab to next field
Living Will	Living Will	If marked on assessment form, enter the alpha value of “N” or “Y” If blank, leave blank and tab to next field
Durable Power of Attorney for Health Care	Durable Power	If marked on assessment form, enter the alpha value of “N” or “Y”
Other	Other	If marked on assessment form, enter the alpha value of “N” or “Y” If blank, leave blank and tab to next field
Diagnosis & Medication Profile		
*Total No of Medications	Total Medicine	Enter value from form. If blank enter default value of “000” <b>If keying from the Adult Care Residence Eligibility Communication Document (Reassessment), key “000”</b>

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
*How do you take your Medicine(s)	Take Medicine	Enter numeric value of 0, 1 or, 2 If blank, leave blank and tab to the next field.
*DX 1	Diagnosis 1	If marked on assessment form, enter the numeric value None = 00 DX1 = Enter 2-digit value from form DX2 = Enter 2-digit value from form DX3 – Enter 2-digit value from form <b>If keying from the Adult Care Residence Eligibility Communication Document, key as coded. If blank, key default value of “00”</b>
*DX 2	Diagnosis 2	If marked on assessment form, enter the numeric value None = 00 DX1 = Enter 2-digit value from form DX2 = Enter 2-digit value from form DX3 – Enter 2-digit value from form <b>If keying from the Adult Care Residence Eligibility Communication Document, key as coded. If blank, key default value of “00”</b>
*DX 3	Diagnosis 3	If marked on assessment form, enter the numeric value None = 00 DX1 = Enter 2-digit value from form DX2 = Enter 2-digit value from form DX3 – Enter 2-digit value from form <b>If keying from the Adult Care Residence Eligibility Communication Document, key as coded. If blank, key default value of “00”</b>
Uniform Assessment Instrument Form Part B – Psycho - Social Assessment		
*Orientation	Orientation	If marked on assessment form, enter the numeric value Oriented = 0 Disoriented – Some spheres, some of the time = 1 Disoriented – Some scpheres, all of the time = 2 Disoriented – All scpheres, some of the time = 3 Disoriented – All scpheres, all of the time = 4

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Short Assessment Keying Instructions		
Assessment Form Field Descriptions	Assessment Form Field Descriptions	Assessment Form Field Descriptions
		Comatose = 5 <b>If keying from the Adult Care Residence Eligibility Communication Document, and the field is blank, key default value of numeric “0”</b>
Short-term Memory Loss	Short term	If marked on assessment form, Enter the Alpha Value of “N” or “Y”  If blank, leave blank and tab to next field
Long-term Memory Loss	Long term	If marked on assessment form, Enter the Alpha Value of “N” or “Y”  If blank, leave blank and tab to next field
Judgment Problems	Judgment	If marked on assessment form, Enter the Alpha Value of “N” or “Y”  If blank, leave blank and tab to next field
*Behavior Pattern	Behavior Pattern	If marked on assessment form, enter the numeric value Appropriate = 0 Wandering/Passive – Less than Weekly = 1 Wandering/Passive – Weekly or More = 2 Abusive/Aggressive/Disruptive – Less than weekly = 3 Abusive/Aggressive/Disruptive – Weekly or More = 4 Comatose = 5 If blank, tab to next field
MMSE Score	MMSE Score	Key as coded

Verify data entered and then click on the “Enter” button which takes you back to Short Assessment or ACRR Page 1

- Click the Update button
- Verify Assessment Status of Approved, Denied or Pended
  - If MMIS error message “Duplicate Assessment” is displayed, research assessment date by following the steps below
    - Key Member ID and Assessment date
    - Go to **Browse Functions:** Click “Assessments by Member”
    - Go to **Select Function:** Click Inquiry then click Enter to advance to the “Assessments By Member Inquiry” screen (AS-S-050)

- Locate the “Assessment Date” and “Assessment Status”
  - If status is “A” or “S” write “Dup Assessment” at the top of the DMAS-96 form and place with other approved Assessments
  - If status is “P” or “D” repeat steps 1-3, select **Function:** , click “Change” then click “Enter “ to advance to the “Short Assessment or ACRR Page 1 – Inquiry screen (AS-S-015)
  - Compare Assessment data to the screen data. If Assessment data is different than the screen data, update the necessary changes within the system and click “Update” to view status
  - If status changes to “Approved”, place with other approved Assessments
  - If status does not change, a TAD is generated

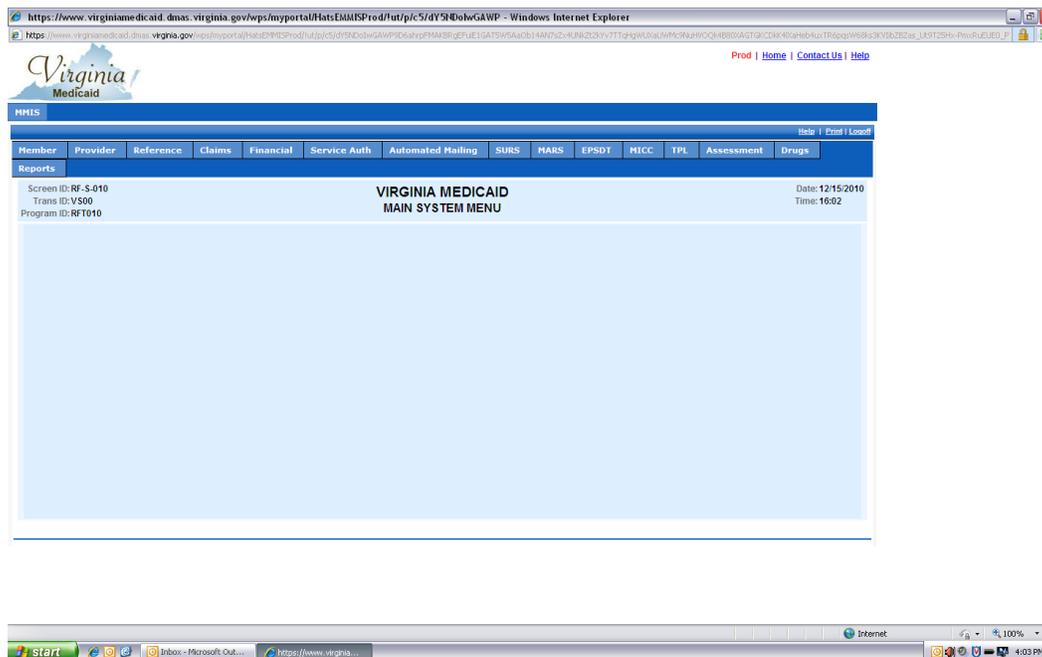
## 2.2.3 DMAS-96 , Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Forms

**🕒 SLA (Service Level Agreement): Process Assessments < 5 working days from receipt with data entry accuracy of 100%**

### Procedure:

1. From the Main System menu, select the Assessments Subsystem icon to display the Assessment Maintenance Menu screen.

**(RF-S-010)**



(screen AS-S-005)

2. On the Assessment Maintenance Menu
  - Enter the SSN or Member ID from the assessment form.
  - Enter the Assessment date without slashes: ex 08182010.
3. Select “Full Assessment or AIDS Waiver” from the Data Entry Functions drop-down box.
4. Click the “Add” radio button to select the task function, and then Click on the “Enter” button to display the “Full Assessment” Page 1 screen.
  - If the MMIS error message “Member Not Active on Date of Screening” displays, go to “adding Member to Enrollment File” procedures found in Section 2.2.5
  - If the MMIS error message “Member on File but not Eligible on Date of Screening”, go to “Adding New Eligibility Segment for Canceled Member” procedures found in Section 2.2.6.
  - If the MMIS error message “Not Medicaid Eligible” or Not Medicaid Eligible on the Day of Screening”, go to “Changing a Member Record” procedures found in Section 2.2.7.

(Screen AS-S-025)

The screenshot shows the 'VIRGINIA MEDICAID FULL ASSESSMENT PAGE 1-ADD' form. At the top, there is a navigation bar with tabs for Member, Provider, Reference, Claims, Financial, Service Auth, Automated Mailing, SUBS, HARS, EPSDT, HICC, TPL, Assessment, and Drugs. The main form area contains the following sections:

- Header:** Screen ID: AS-S-025, Trans ID: WFE3, Program ID: AST025, Date: 12/08/2010, Time: 15:19.
- Member Information:** Assessment Control Number, SSN, Last Name, First Name, Member ID, Address (1503 DADE LAKE, ALEXANDRIA, VA 22308 1835), Reassessment (Y/N), Assessment Date (03282007), M/I, Suffix, and Assessment Status.
- DMAS-96 and DMAS-96 MIMR Supplemental:** Includes checkboxes for Medicaid Eligibility, Physician Auth Date, Medicaid Application, Auxiliary Grant, Medicaid Authorization, Level I Scr 1, Target Case Management, Service Availability, Length of Stay, Level I Scr 2, Level II MI, Patient Expired, Level II Assessment, Level II Scr, and Level II M/R.
- UAI - Demographics:** Includes fields for DOB (04/02/1926), Gender (F), Marital Status (U), Race (2), and various service needs like Com of Needs, Adult Daycare, Adult Protect, Case Mgmt, Chore/Compan, Congregate, Finance Mgmt, Friendly Visit, Habilitation, Home Deliver, Home Health, Home Repairs, Housing, Legal, Mental Health, Mental Retra, Personal Care, Respite, Subst Abuse, Transport, Vocational, and Other Services.

At the bottom, there are buttons for Enter, Update, Clear Form, Refresh, Name Search, LOC, Del Seg, Cur Seg, Return, Sub Menu, and Main Menu. Below these are navigation buttons for Lvl Scr1, Lvl Scr2, Lvl Scr, and Next.

5. Key assessment information in entry screen fields using the DMAS-96, Adult Care Residence Eligibility Communications and Uniform Assessment Instrument (UAI)- Full Assessment Keying Instructions.
  - If provider submit both a “DMAS-96 Form” that is coded with an authorization level of (12) along with a “Reassessment Form” that has a check mark for Residential Living (Level 11), return to the provider requesting which level should be used
  - **If keying from the “Adult Care Residence Eligibility Communication Document” (Reassessment), key only those fields that are preceded by an asterisk. This applies only to Authorization Level 12**
  - If keying fields have multiple answers, leave blank and proceed keying
  
6. Verify data entered then click the “Enter” button to display the Full “Assessment” Page 2 screen.

(Screen AS-S-030)

Screen ID: AS-S-030  
Trans ID: VFE3  
Program ID: AST025

**VIRGINIA MEDICAID  
FULL ASSESSMENT PAGE 2 - ADD**

Date: 12/08/2010  
Time: 15:24

Assessment Control Number: [Redacted] SSI# [Redacted] Source Code: PSAC First Name: [Redacted] MI: [Redacted] Assessment Status: Assessment Date: 03/28/2007

**UAI - Financial Resources**

Legal Guardian: <input type="checkbox"/>	Power of Attorney: <input type="checkbox"/>	Rep Payee: <input type="checkbox"/>	Other Rep: <input type="checkbox"/>
Auxiliary Grant: <input type="checkbox"/>	Food Stamps: <input type="checkbox"/>	Fuel Assist: <input type="checkbox"/>	General Relief: <input type="checkbox"/>
State/Local: <input type="checkbox"/>	Subsidized Housing: <input type="checkbox"/>	Tax Relief: <input type="checkbox"/>	Medicare Insure: <input type="checkbox"/>
MC QMB/SLMB: <input type="checkbox"/>	All Other Ins: <input type="checkbox"/>	Medicaid Insure: <input type="checkbox"/>	Medicaid Pending: <input type="checkbox"/>

Medicare Number: [Redacted]

**UAI - Physical Environment/Functional Status**

Residence: <input type="checkbox"/>	Bathing: <input type="checkbox"/>	Dressing: <input type="checkbox"/>	Toileting: <input type="checkbox"/>
Transferring: <input type="checkbox"/>	Eating/Feeding: <input type="checkbox"/>	Bowel: <input type="checkbox"/>	Bladder: <input type="checkbox"/>
Walking: <input type="checkbox"/>	Wheeling: <input type="checkbox"/>	Stairclimb: <input type="checkbox"/>	Mobility: <input type="checkbox"/>
Meal Prepare: <input type="checkbox"/>	Housekeeping: <input type="checkbox"/>	Laundry: <input type="checkbox"/>	Money Mgmt: <input type="checkbox"/>
Transport: <input type="checkbox"/>	Shopping: <input type="checkbox"/>	Using Phones: <input type="checkbox"/>	Home Maintenance: <input type="checkbox"/>

**UAI - Physical Health Assessment**

Hospital: <input type="checkbox"/>	Nursing Facility: <input type="checkbox"/>	Adult Care: <input type="checkbox"/>	Living Will: <input type="checkbox"/>
Other Adv Dir: <input type="checkbox"/>	Diagnosis 1: <input type="checkbox"/>	Diagnosis 2: <input type="checkbox"/>	Diagnosis 3: <input type="checkbox"/>
Durable Power: <input type="checkbox"/>	Total Medicine: <input type="checkbox"/>	Take Medicine: <input type="checkbox"/>	

Enter Clear Form Refresh LOC Previous Next Return Sub Menu Main Menu

7. Enter Assessment form data fields:
8. Verify data entered and then click on the “Enter” button to display the “Full Assessment” Page 3 screen.

(Screen AS-S-035)

Screen ID: AS-S-035  
Trans ID: VFE3  
Program ID: AST025

**VIRGINIA MEDICAID  
FULL ASSESSMENT PAGE 3 - ADD**

Date: 12/08/2010  
Time: 15:26

Assessment Control Number: [Redacted] SSI# [Redacted] Source Code: PSAC First Name: MARY MI: M Assessment Status: Assessment Date: 03/28/2007

**UAI - Physical Health Assessment (Continued)**

Vision: <input type="checkbox"/>	Hearing: <input type="checkbox"/>	Speech: <input type="checkbox"/>	Joint Motion: <input type="checkbox"/>
Fractures: <input type="checkbox"/>	Missing Limbs: <input type="checkbox"/>	Para/Pareisis: <input type="checkbox"/>	Height: <input type="checkbox"/>
Weight: <input type="checkbox"/>	WT Gain/Loss: <input type="checkbox"/>	Occupational: <input type="checkbox"/>	Physical: <input type="checkbox"/>
Reality/Remo: <input type="checkbox"/>	Respiratory: <input type="checkbox"/>	Speech Therapy: <input type="checkbox"/>	Other Med Serv: <input type="checkbox"/>
Pressure Ulcers: <input type="checkbox"/>	Bowel: <input type="checkbox"/>	Dialysis: <input type="checkbox"/>	Wound Dressing: <input type="checkbox"/>
Eye Care: <input type="checkbox"/>	Glucose: <input type="checkbox"/>	Injections: <input type="checkbox"/>	Oxygen: <input type="checkbox"/>
Radiation: <input type="checkbox"/>	Restraints: <input type="checkbox"/>	ROM Exercise: <input type="checkbox"/>	Trach Care: <input type="checkbox"/>
Ventilator: <input type="checkbox"/>	Other Proced: <input type="checkbox"/>	Nursing Needs: <input type="checkbox"/>	

**UAI - Psycho-Social Assessment**

Orientation: <input type="checkbox"/>	Short Term: <input type="checkbox"/>	Long Term: <input type="checkbox"/>	Judgement: <input type="checkbox"/>
Behavior Pat: <input type="checkbox"/>	MMSE Score: <input type="checkbox"/>	Hosp/Alcohol: <input type="checkbox"/>	

**UAI - Assessment Summary**

Caregiver: <input type="checkbox"/>	Caregiver Live: <input type="checkbox"/>	Caregiver Help: <input type="checkbox"/>	Caregiver Burd: <input type="checkbox"/>
Finances: <input type="checkbox"/>	Home/Environ: <input type="checkbox"/>	ADL S: <input type="checkbox"/>	IADL S: <input type="checkbox"/>
Asst Devices: <input type="checkbox"/>	Medical Care: <input type="checkbox"/>	Nutrition: <input type="checkbox"/>	Cognitive/EMO: <input type="checkbox"/>
Caregiver Supp: <input type="checkbox"/>			

Enter Clear Form Refresh LOC Previous Return Sub Menu Main Menu

9. Enter Assessment form data fields:
10. Verify data entered and then click on the “Enter” button.

## 2.2.4 DMAS-96, Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI)-Full Assessment Keying Instructions

DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions		
Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
*Assessment Control Number	Assessment Control Number	Key ACN from back of first page
Social Security or Member ID	SSN or Member ID	Auto Populated
*Residential Living	Reassessment	<b>Key “Y”</b> if keying from the “Adult Care Residence Eligibility Communication Document” (Reassessment). This applies only to Authorization Level <b>12</b> . <b>If the Reassessment form is not present, key “N”</b>
Last Name	Last Name	Auto Populated unless enrollement is needed
First Name	First Name	Auto Populated unless enrollement is needed
Not on form	MI	
Not on Form	Suffix	
Medicaid ID	Member ID	Auto Populated unless enrollement is needed
*Is the Individual Currently Medicaid Eligible?	Medicaid Eligibility	<b>If the Adult Care Residence Eligibility Communication Document (Reassessment) is submitted, key the default value of “1”</b>  If marked on assessment form, enter the numeric value

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>Yes = 1</p> <p>Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission OR within 45 days of application or when personal care begins = 2</p> <p>Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission = 3</p>
<u>*Level I Physician</u>	<u>Physician Authorization Date</u>	<p><u>Enter the “Date” signed by Level I Physician.</u></p> <p><u>Must Be MMDDYYYY format.</u></p> <p><u>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment), key the Reassessment date.</u></p>
*If no, has Individual formally applied for Medicaid?	Medicaid Application	Always enter “Y”
*Is Individual currently Auxiliary Grant eligible?	Auxiliary Grant	<p>If marked on assessment form, enter the alpha value of “Y” or “N”:</p> <p>If blank, tab to next field</p> <p><b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment), always key “Y”</b></p>
*Level of Care	Medicaid Authorization	<p>If marked on assessment form, enter the numeric value</p> <p>Nursing Facility (NF) Services = 01</p> <p>Pace = 02</p> <p>AIDS/HIV Waiver Services = Reject</p> <p>Elderly or Disabled w/Consumer Direction (EDCD) Waiver = 04</p>

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>ALF Regular Assisted Living = 12                      Individual/Family Developmental Disabilities Waiver = 14                      Technology Assisted Waiver = 15                      Alzheimer’s Assisted Living Waiver = 16                      Note AFL Residential Living (11) is not a valid entry for Full Assessments</p> <p><b>No Medicaid Services Authorized</b>                      Other Services Recommended = 8                      Active Treatment for MI/MR Condition = 9                      No other services recommended = 0</p> <p>If blank, tab to the next field</p> <p><b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment) always key “12”</b></p>
*Targeted Case Management for ALF	Target Case Management	<p>If marked on assessment form, enter the alpha value of “N” or “Y”                      If blank, tab to next field</p> <p><b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment) always key “N”</b></p>
*Service Availability	Service Availability	<p>If marked on assessment form, enter the numeric value</p> <p>Client on waiting list for service authorized = 1</p>

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>Desired service provider not available = 2                      Service provider available, care to start immediately = 3                      If blank or values not listed above, key in default value of "9"</p> <p><b>If keying from the "Adult Care Residence Eligibility Communication Document", (Reassessment) always key "9"</b></p>
*Length of Stay	Length of Stay	<p>If marked on assessment form, enter the numeric value                      Temporary (less than 3 months) = 1                      Temporary (less than 6 months) = 2                      Continuing (more than 6 months) = 3                      If blank or values not listed above, key in default value of "8"</p> <p><b>If keying from the "Adult Care Residence Eligibility Communication Document", (Reassessment) always key "8"</b></p>
*Level I/AFL Screening Identification (Line 1)	Level I SCR 1	<p>Enter the first 10-digit NPI located on Line 1                      If blank, invalid or not eligible, return to DMAS. Invalid and not eligible documents will be returned with a screen print indicating the error message. Blank documents will not have a screen print attached..</p> <p><b>If keying from the "Adult Care Residence Eligibility Communication Document", (Reassessment) always key</b></p>

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<b>The Assessor's provider #</b>
Level I/AFL Screening Identification (Line 2)	Level I SCR 2	<p>Key the 10 digit NPI                      If invalid, have Team Lead look up Provider address using Provider name and return to provider. with a screen print attached.</p> <p>If Level I SCR 1 is coded, and Level 2 SCR 2 is blank, tab to next field</p> <p>If Level 1 SCR 1 is blank, key Level 1 SCR 2 10 digit NPI into the Level 1 SCR 1 field.</p>

**DMAS 95 Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions Form**

*Level II Assessment Determination – FOR NF AUTHS ONLY – DOES NOT APPLY TO WAIVERS or ASSISTED LIVING SERVICES, Applies only to Authorization Level 01	Level II Assessment	<p>Key the 10 digit NPI</p> <p>If NPI is coded, an assessment value other than zero must be coded. If not, return to provider</p> <p>If NPI is blank, and the Assessment Value is blank, key default value of "0".</p> <p>If a value code other than zero is coded but no NPI, return to provider.</p> <p>If marked on assessment form, enter the numeric value                      Not referred for level II Assessment = 0                      Referred, Active Treatment needed = 1                      Referred, Active Treatment not needed = 2                      Referred, Active Treatment needed but individual chooses NH = 3</p>
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**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>If</p> <p>If zero is coded, tab to next field</p> <p>If coded value = 1, 2 or 3, look for the “Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions” form</p> <p>Go to question 5a - Recommendation –</p> <p>If MI,MR or Dual Diagnosis box is checked key “Y”</p> <p>If blank, highlight the Recommendation boxes and place an asterisk beside the block number and return to provider</p> <p><b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment) always key numeric “0”</b></p>
Does the Individual Have a Current Serious Mental Illness (MI)	Level II M/I	<p>Enter the value for selected option</p> <p>Yes = Y</p> <p>No = N</p>
Does the individual have a diagnosis of mental retardation (MR)/Intellectual Disability (ID) which was manifested before age 18?	Level II M/R	<p>Enter the value for selected option</p> <p>Yes = Y</p> <p>No = N</p>
Does the individual have a related condition?	Dual Diagnosis	<p>Enter the value for selected option</p> <p>Yes = Y</p> <p>No = N</p>
*Did the individual expire after the PAS/ALF Screening decision but before services	Patient Expired	<p>If marked on assessment form, Enter the alpha value of “N” or “Y”</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
were received		If blank, tab to next field  <b>If keying from the “Adult Care Residence Eligibility Communication Document”, (Reassessment) always key “N”</b>
Level II Assessment Determination (Line 1)	Level II SCR	Enter the first 10-digit Number located on Line 2
Uniform Assessment Instrument Form Part A – Demographics		
Birthdate	Birth Date	MMDDYYYY
Sex (Male or Female)	Gender	Auto Populated
Marital Status	Marital Status	Auto Populated
Race	Race	Auto Populated
*Communication of Needs	Com of Needs	Enter Numeric Value Verbally, English = 0 Verbally, Other Language = 1 Sign Language/Gestures/Device = 2 Does Not Communicate = 3  If blank, highlight the Communication of Needs block, place an asterisk beside the block and return to provider  Tab to next field

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<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
<b>Uniform Assessment Instrument Form Part A – Current Formal Services</b>		
Adult Day Care	Adult Daycare	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Adult Protective	Adult Protect	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Case Management	Case Mgmt	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Chore/Companion/Homemaker	Chore/Compan	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Congregate Meals/Senior Center	Congregate	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Financial Management/Counseling	Finance Mgmt	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Friendly Visitor/Telephone Reassurance	Friendly Visit	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Habitation/Supported Employment	Habitation	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Home Delivered Meals	Home Deliver	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Home Health/Rehabilitation	Home Health	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Home Repairs / Weatherization	Home Repairs	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Housing	Housing	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field

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<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
Legal	Legal	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Mental Health (Inpatient/Outpatient)	Mental Health	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Mental Retardation	Mental Retrd	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Personal Care	Personal Care	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Respite	Respite	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Substance Abuse	Subst Abuse	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Transportation	Transport	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Vocational rehab/Job Counseling	Vocational	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Other	Other Services	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field

**Uniform Assessment Instrument Part A – Financial Resources**

Legal Guardian	Legal Guardian	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Power of Attorney	Power of Attorney	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Representative Payee	Rep Payee	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field

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<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
Other	Other Rep	If marked on assessment form, Enter “Y” or “N” If blank, tab to next
Auxiliary Grant	Auxiliary Grant	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Food Stamps	Food Stamps	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Fuel Assistance	Fuel Assist	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
General Relief	General Relief	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
State and Local Hospitalization	State/Local	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Subsidized Housing	Subsidized Housing	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Tax Relief	Tax Relief	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Medicare	Medicare Insure	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Medicare #	Medicare Number	This is not a required field. When coded, tab to next field.
QMB/SLMB	MC QMB/LMB	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
All Other Public/Private	All Other Ins	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field
Medicaid	Medicaid Insure	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
Medicaid Pending	Medicaid Pending	If marked on assessment form, Enter “Y” or “N” If blank, tab to next field

**Uniform Assessment Instrument Part A – Physical Environment**

*Where do you usually live? Does anyone live with you?	Residence	<p>Always key from left to right to enter (2) digit numeric value If only one value per line is coded, highlight the line, place an asterisk on the outside of the check box and tab to next field</p> <p>Blocks 50,60,70,80 and 90 should be keyed with the two digit number listed beside the wording. Opposed to keying left to right</p> <p>Ignore any names or comments in the Name of Persons in Household column</p> <p>If Where Do you Usually Live blocks is checked and the Facility blocks are checked, key only the facility code.</p> <p>Enter numeric Value House / Own and Alone = 01 House / Rent and Alone = 11 House / Other and Alone = 21 Apartment and Alone = 31 Rented Room and Alone = 41</p> <p>House/Own and Spouse = 02 House/Rent and Spouse = 12 House/Other and Spouse = 22 Apartment and Spouse = 32 Rent Room and Spouse = 42</p> <p>House / Own and Other = 03 House / Rent and Other = 13</p>
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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>House / Other and Other = 23                      Apartment and Other = 33                      Rented Room and Other = 43</p> <p>Adult Care Residence = 50                      Adult Foster = 60                      Nursing Facility = 70                      Mental Health/Retardation Facility = 80                      Other = 90</p>
<b>Uniform Assessment Instrument Part A – Functional Status</b>		
*Bathing	Bathing	<p>If marked on assessment form, Enter the Numeric Value                      Review the “Needs Help?” field. If “No” marked enter numeric value “00”</p> <p>MH Only/Mechanical Help = 10                      HH Only/Human Help and Supervision = 21                      HH Only/Human Help and Physical Assistance = 22                      MH &amp; HH and Supervision = 31                      MH &amp; HH and Physical Assistance = 32                      Performed by Others = 40</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Dressing	Dressing	<p>If marked on assessment form, Enter the Numeric Value</p> <p>Review the “Needs Help?” field. If “No” marked enter</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>value "00"</p> <p>MH Only/Mechanical Help = 10</p> <p>HH Only/Human Help and Supervision = 21</p> <p>HH Only/Human Help and Physical Assistance = 22</p> <p>MH &amp; HH and Supervision = 31</p> <p>MH &amp; HH and Physical Assistance = 32</p> <p>Performed by Others = 40</p> <p>Is Not Performed = 50</p> <p>If "Yes" block is checked but no "Level of Functioning" is checked, leave blank and tab to the next field.</p> <p>If "No" block is checked, and a "Level of Functioning" is coded, key the numeric default value of "00".</p>
*Toileting	Toileting	<p>If marked on assessment form, Enter the Numeric Value</p> <p>Review the "Needs Help?" field. If "No" marked enter value "00"</p> <p>MH Only/Mechanical Help = 10</p> <p>HH Only/Human Help and Supervision = 21</p> <p>HH Only/Human Help and Physical Assistance = 22</p> <p>MH &amp; HH and Supervision = 31</p> <p>MH &amp; HH and Physical Assistance = 32</p> <p>Performed by Others = 40</p> <p>Is Not Performed = 50</p> <p>If "Yes" block is checked but no "Level of Functioning" is checked, leave blank and tab to the next field.</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Transferring	Transferring	<p>If marked on assessment form, Enter the Numeric Value</p> <p>Review the “Needs Help?” field. If “No” marked enter value “00”</p> <p>MH Only/Mechanical Help = 10            HH Only/Human Help and Supervision = 21            HH Only/Human Help and Physical Assistance = 22            MH &amp; HH and Supervision = 31            MH &amp; HH and Physical Assistance = 32            Performed by Others = 40            Is Not Performed = 50</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Eating/Feeding	Eating/Feeding	<p>If marked on Assessment form, enter the numeric value</p> <p>Review the “Need Help?” field. If “No” marked enter value “00”.</p> <p>MH Only/Mechanical Help= 10            HH Only/Human Help and Supervision= 21            HH Only/Human Help and Physical Assistance= 22</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>MH &amp; HH and Supervision= 31                      MH &amp; HH and Physical Assistance= 32                      Performed by Others and Spoon Fed= 41                      Performed by Others and Syringe/Tube Fed= 42                      Performed by Others and Fed by IV= 43</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Bowel	Bowel	<p>If marked on assessment form, Enter the Numeric Value                      No = 0                      Yes = 1, 2, 3 or 6</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “0”.</p>
*Bladder	Bladder	<p>If marked on assessment form, Enter the Numeric Value                      No = 0                      Yes = 1-6</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>“Level of Functioning” is coded, key the numeric default value of “0”.</p>
*Walking	Walking	<p>If marked on assessment form, Enter the Numeric Value Review the “Needs Help?” field. If “No” marked enter numeric value “00” MH Only/Mechanical Help = 10 HH Only/Human Help and Supervision = 21 HH Only/Human Help and Physical Assistance = 22 MH &amp; HH and Supervision = 31 MH &amp; HH and Physical Assistance = 32</p> <p>If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Wheeling	Wheeling	<p>If marked on assessment form, Enter the Numeric Value Review the “Needs Help?” field. If “No” marked enter numeric value “00” MH Only/Mechanical Help = 10 HH Only/Human Help and Supervision = 21 HH Only/Human Help and Physical Assistance = 22 MH &amp; HH and Supervision = 31 MH &amp; HH and Physical Assistance = 32 Performed by Others = 40 If “Yes” block is checked but</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>no "Level of Functioning" is checked, leave blank and tab to the next field.</p> <p>If "No" block is checked, and a "Level of Functioning" is coded, key the numeric default value of "00".</p>
*Stairclimbing	Stairclimb	<p>If marked on assessment form, Enter the Numeric Value</p> <p>Review the "Needs Help?" field. If "No" marked enter numeric value "00"</p> <p>MH Only/Mechanical Help = 10</p> <p>HH Only/Human Help and Supervision = 21</p> <p>HH Only/Human Help and Physical Assistance = 22</p> <p>MH &amp; HH and Supervision = 31</p> <p>MH &amp; HH and Physical Assistance = 32</p> <p>If "Yes" block is checked but no "Level of Functioning" is checked, leave blank and tab to the next field.</p> <p>If "No" block is checked, and a "Level of Functioning" is coded, key the numeric default value of "00".</p>
*Mobility	Mobility	<p>If marked on assessment form, Enter the Numeric Value</p> <p>Review the "Needs Help?" field. If "No" marked enter numeric value "00"</p> <p>MH Only/Mechanical Help = 10</p> <p>HH Only/Human Help and Supervision = 21</p> <p>HH Only/Human Help and Physical Assistance = 22</p> <p>MH &amp; HH and Supervision = 31</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>MH &amp; HH and Physical Assistance = 32                      Performed by Others = 40                      If “Yes” block is checked but no “Level of Functioning” is checked, leave blank and tab to the next field.</p> <p>If “No” block is checked, and a “Level of Functioning” is coded, key the numeric default value of “00”.</p>
*Meal Preparation	Meal Prepare	<p>If marked on assessment form, Enter the Alpha Value “N” or “Y”                      If not checked, leave blank and tab to the next field</p>
*Housekeeping	Housekeeping	<p>If marked on assessment form, Enter the Alpha Value “N” or “Y”                      If not checked, leave blank and tab to the next field</p>
*Laundry	Laundry	<p>If marked on assessment form, Enter the Alpha Value “N” or “Y”                      If not checked, leave blank and tab to the next field</p>
*Money Mgmt	Money Mgmt	<p>If marked on assessment form, Enter the Alpha Value “N” or “Y”                      If not checked, leave blank and tab to the next field</p>
*Transportation	Transport	<p>If marked on assessment form, Enter the Alpha Value “N” or “Y”                      If not checked, leave blank and tab to the next field</p>

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<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
*Shopping	Shopping	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
*Using Phone	Using Phone	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
*Home Maintenance	Home Maintenance	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
<b>Uniform Assessment Instrument Part B – Physical Health Assessment</b>		
*Hospital	Hospital	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
*Nursing Facility	Nursing Facility	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
*Adult Care Residence	Adult Care	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
*Living Will	Living Will	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
*Other	Others	If marked on assessment form, Enter the Alpha Value “N” or “Y” If not checked, leave blank and tab to the next field
*DX 1	Diagnosis 1	If marked on assessment form, Enter the Numeric Value None = 00 DX1 = Enter 2-digit value from form DX2 = Enter 2-digit value from form DX3 = Enter 2-digit value from form If “None” and only one Diagnosis code is listed, key default value of numeric “00” in remaining Diagnosis fields
*DX 2	Diagnosis 2	If marked on assessment form, Enter the Numeric Value None = 00 DX1 = Enter 2-digit value from form DX2 = Enter 2-digit value from form DX3 – Enter 2-digit value from form If “None” and only one Diagnosis code is listed, key default value of numeric “00” in remaining Diagnosis fields
*DX 3	Diagnosis 3	If marked on assessment form, Enter the Numeric Value None = 00 DX1 = Enter 2-digit value from form DX2 = Enter 2-digit value from form DX3 = Enter 2-digit value from form If “None” and only one

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		Diagnosis code is listed, key default value of numeric "00" in remaining Diagnosis fields
*Durable Power of Attorney for Health Care	Other Adv Dir	If marked on assessment form, Enter the Alpha Value "N" or "Y" If not checked, leave blank and tab to the next field
*Total No. of Medications	Total Medicine	Enter value from form. If blank tab to the next field. <b>If keying from the Adult Care Residence Eligibility Communication Document (Reassessment),key "000"</b>
*How do you take your medicine?	Take Medicine	If marked on assessment form, Enter the Numeric Value  Without Assistance = 0 Administered/monitored by lay person = 1 Administered/professional nursing staff = 2 If blank, leave blank and click enter
*Vision	Vision	If marked on assessment form, Enter the Numeric Value No Impairment = 0 Impairment – Compensation = 1 Impairment – No Compensation = 2 Complete Loss = 3 If blank, tab to next field  If a description is coded opposed to a check mark, key the numeric value associated with the block the description is coded in
*Hearing	Hearing	If marked on assessment form, Enter the Numeric Value No Impairment = 0 Impairment – Compensation =

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>1                      Impairment – No Compensation = 2                      Complete Loss = 3                      If blank, tab to next field</p> <p>If a description is coded opposed to a check mark, key the numeric value associated with the block the description is coded in</p>
*Speech	Speech	<p>If marked on assessment form, Enter the Numeric Value                      No Impairment = 0                      Impairment – Compensation = 1                      Impairment – No Compensation = 2                      Complete Loss = 3                      If blank, tab to next field</p> <p>If a description is coded opposed to a check mark, key the numeric value associated with the block the description is coded in</p>
*Joint Motion: How is your ability to move your arms, fingers, and legs?	Joint Motion	<p>If marked on assessment form, Enter the Numeric Value                      Within Normal limits or instability corrected = 0                      Limited Motion = 1                      Instability uncorrected or immobile = 2                      If blank or multiple check marks are coded, leave blank and tab to next field.</p>
*Fractures/Dislocations	Fractures	<p>If marked on assessment form, enter the numeric Values from each option.                      If “None” is not checked, All three options must have a selection marked or leave field blank. (This is a 3-digit field)                      Valid Values                      None = 000</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		<p>Hip Fracture value = 1                      Other Broken Bones = 2                      Dislocation(s) = 3                      Combination = 4</p> <p><b>Previous Rehab Program?</b>                      No/Not Completed = 1                      Yes = 2</p> <p><b>Date of Fracture/Dislocation</b>                      1 Year or Less = 1                      More than 1 Year = 2</p>
*Missing Limbs	Missing Limbs	<p>If marked on assessment form, Enter the Numeric Values from each option. If “None” is not checked, All three options must have a selection marked or leave field blank. (This is a 3-digit field)</p> <p>Valid Values                      None = 000                      Finger(s)/Toe(s) = 1                      Arm(s) = 2                      Leg(s) = 3                      Combination = 4</p> <p><b>Previous Rehab Program?</b>                      No/Not Completed = 1                      Yes = 2</p> <p><b>Date of Amputation?</b>                      1 Year or Less = 1                      More than 1 Year = 2</p>
*Paralysis/Paresis	Para/Paresis	<p>If marked on assessment form, Enter the Numeric Values from each option. If “None” is not checked, All three options must have a selection marked or leave field blank. (This is a 3-digit field)</p> <p>Valid Values</p>

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		None = 000 Partial = 1 Total = 2 <b>Previous Rehab Program?</b> No/Not Completed = 1 Yes = 2  <b>Onset of Paralysis?</b> 1 Year or Less = 1 More than 1 Year = 2
*Height	Height	If marked on assessment form, convert Height to Inches and enter the Numeric Value  If blank, key default value of "060" (This is a 3-digit field)
*Weight	Weight	If marked on assessment form, Enter the Numeric Value If blank, key default value of "600" (This is a 3-digit field).
*Recent Weight Gain/Loss	WT Gain/Loss	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Occupational	Occupational	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Physical	Physical	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field

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<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
*Reality/Remotivation	Reality/Remo	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Respiratory	Respiratory	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Speech	Speech Therapy	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Other	Other Med Serv	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Do you have pressure ulcers	Pressure Ulcers	If marked on assessment form, Enter the Numeric Value None = 0 Stage I =1 Stage II =2 Stage III = 3 Stage IV = 4 If blank or multiple check marks are coded, leave blank and tab to next fieldt
*Bowel/Bladder Training	Bowel	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab

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Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		to next field
*Dialysis	Dialysis	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Dressing/Wound Care	Wound Dresng	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Eye Care	Eye Care	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Glucose/Blood Sugar	Glucose	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Injections/ IV Therapy	Injections	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Oxygen	Oxygen	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
*Radiation/Chemotherapy	Radiation	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Restraints (Physical/Chemical	Restraints	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*ROM Exercise	ROM Exercise	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Trach care/Suctioning	Trach Care	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Ventilator	Ventilator	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Other	Other Proced	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
*Are there ongoing medical/nursing needs	Nursing Needs	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
<b>Uniform Assessment Instrument Part B – Psycho Social Assessment</b>		
*Orientation	Orientation	If marked on assessment form, Enter the Numeric Value Oriented = 0 Disoriented – Some spheres, some of the time = 1 Disoriented – Some spheres, all of the time = 2 Disoriented – All spheres, some of the time = 3 Disoriented – All spheres, all of the time = 4 Comatose = 5 If blank or multiple check marks are coded, leave blank and tab to next fieldt
*Short-term Memory Loss	Short Term	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field
*Long-term Memory Loss	Long Term	If marked on assessment form, Enter the Alpha Value of "N" or "Y"  If blank, leave blank and tab to next field

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
*Judgment Problems	Judgment	If marked on assessment form, Enter the Alpha Value of “N” or “Y”  If blank, leave blank and tab to next field
*Behavior Pattern	Behavior Pat	If marked on assessment form, Enter the Numeric Value Appropriate = 0 Wandering/Passive – Less than Weekly = 1 Wandering/Passive – Weekly or More = 2 Abusive/Aggressive/Disruptive – Less than weekly = 3 Abusive/Aggressive/Disruptive – Weekly or More = 4 Comatose = 5 If blank or multiple check marks are coded, leave blank and tab to next fieldt
*MMSE Score	MMSE Score	Enter the numeric value located in the “Total” field This is a 3 digit field If blank, tab to next field
*Have you been hospitalized or received inpatient/outpatient treatment in the past 2 years for nerves, emotional/mental health, alcohol, or substance abuse problems?	Hosp/Alcohol	If marked on assessment form, Enter the Alpha Value of “N” or “Y”  If blank, leave blank and tab to next field

**Uniform Assessment Instrument Part B – Assessment Summary**

*Does the client have an informal caregiver?	Caregiver	If marked on assessment form, Enter the Alpha Value of “N” or “Y”  If blank, leave blank and tab to next field  If “N” and “Y” are both marked, leave blank  If neither “N” or “Y” are
--	-----------	--

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
		marked, leave the next three fields blank
*Where does the caregiver live?	Caregiver Live	If marked on assessment form, Enter the Numeric Value With Client = 0 Separate residence, close proximity = 1 Separate residence, over 1 hour away = 2 <b>If the “Does the client have an informal caregiver?” block is check “No”, key default value of “9”</b>
*Is the caregiver’s help....	Caregiver Help	If marked on assessment form, Enter the Numeric Value Adequate to meet the clients needs = 0 Not Adequate to meet the clients needs = 1 <b>If the “Does the client have an informal caregiver?” block is check “No”, key default value of “9”</b>
*Has providing care to client become a burden for the caregiver?	Caregiver Burd	If marked on assessment form, Enter the Numeric Value Not at all = 0 Somewhat = 1 Very much = 2 <b>If the “Does the client have an informal caregiver?” block is check “No”, key default value of “9”</b>
*Finances	Finances	If marked on assessment form, Enter the Alpha Value of “N” or “Y” If blank, leave blank and tab to next field

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

<b>Assessment Form Field Descriptions</b>	<b>Data Entry Screen Field Descriptions</b>	<b>Data Entry Procedure</b>
*Home/Physical Environment	Home/Environ	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field
*ADLS	ADLS	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field
*IADLS	IADLS	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field
*Assistive Devices/Medical Equipment	Asst Device	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field
*Medical Care/Health	Medical Care	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field
*Nutrition	Nutrition	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field
*Cognitive/Emotional	Cognitive/EMO	If marked on assessment form, Enter the Alpha Value of "N" or "Y" If blank, leave blank and tab to next field

**DMAS-96 Adult Care Residence Eligibility Communication and Uniform Assessment Instrument (UAI) – Full Assessment Keying Instructions**

Assessment Form Field Descriptions	Data Entry Screen Field Descriptions	Data Entry Procedure
*Caregiver Support	Caregiver Supp	If marked on assessment form, Enter the Alpha Value of “N” or “Y” If blank, leave blank and tab to next field

Verify data entered and then click on the “Enter” button which takes you back to Full Assessment Page 1.

- Click the Update button
- Verify Assessment Status of Approved, Denied or Pended
  - If MMIS error message “Duplicate Assessment” is displayed, research assessment date by following the steps below
    - Key Member ID and Assessment date
    - Go to **Browse Functions:** Click “Assessments by Member”
    - Go to **Select Function:** Click Inquiry then click Enter to advance to the “Assessments By Member Inquiry” screen (AS-S-050)
    - Locate the “Assessment Date” and “Assessment Status”
      - If status is “A” or “S” write “Dup Assessment” at the top of the DMAS-96 form and place with other approved Assessments
      - If status is “P” or “D” repeat steps 1-3, select **Function:** , click “Change” then click “Enter “ to advance to the “Full Assessment Page 1 – Inquiry screen
      - Compare Assessment data to the screen data. If Assessment data is different than the screen data, update the necessary changes within the system and click “Update” to view status
      - If status changes to “Approved”, place with other approved Assessments
      - If status does not change, a TAD is generated

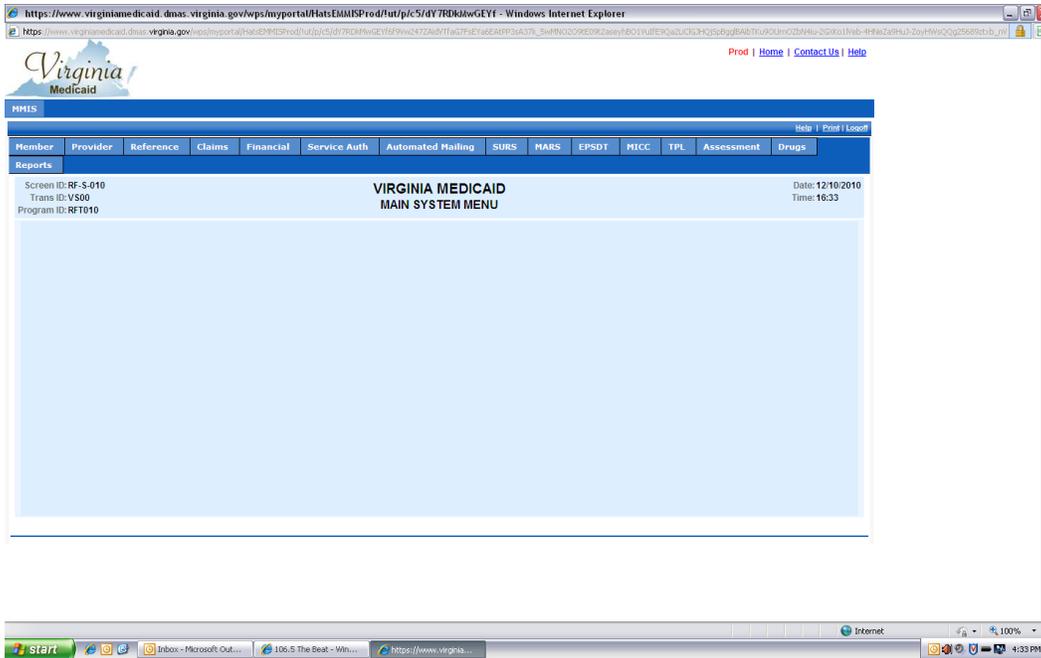
### 2.2.5 Adding Person to Enrollment File

Assessment forms cannot be entered into the MMIS unless the person being screened is on the MMIS Member File and is active on the screening date. For assessments that screen persons to determine eligibility, it is likely that the person is not already on file and active. If you are attempting to key an assessment form and the system states the person is not on file, you need to add the person to the enrollment file before entering the assessment.

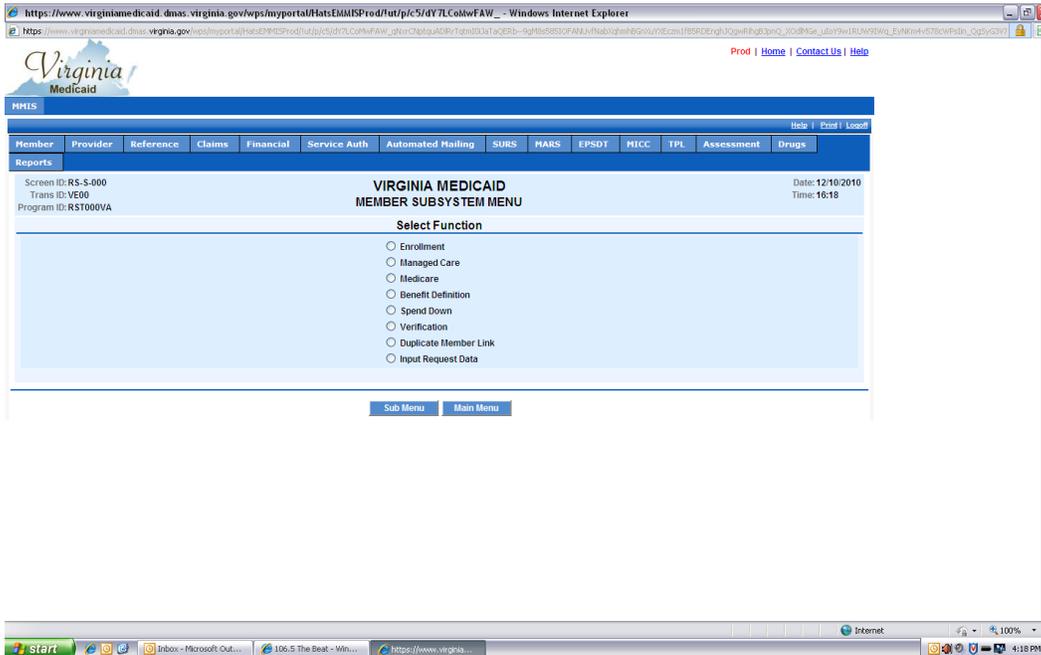
**Procedure:**

1. Access the MMIS Main Menu screen.

**(RF-S-010)**



2. Click on the Member button to display the Member Subsystem menu (screen RS-S-000)

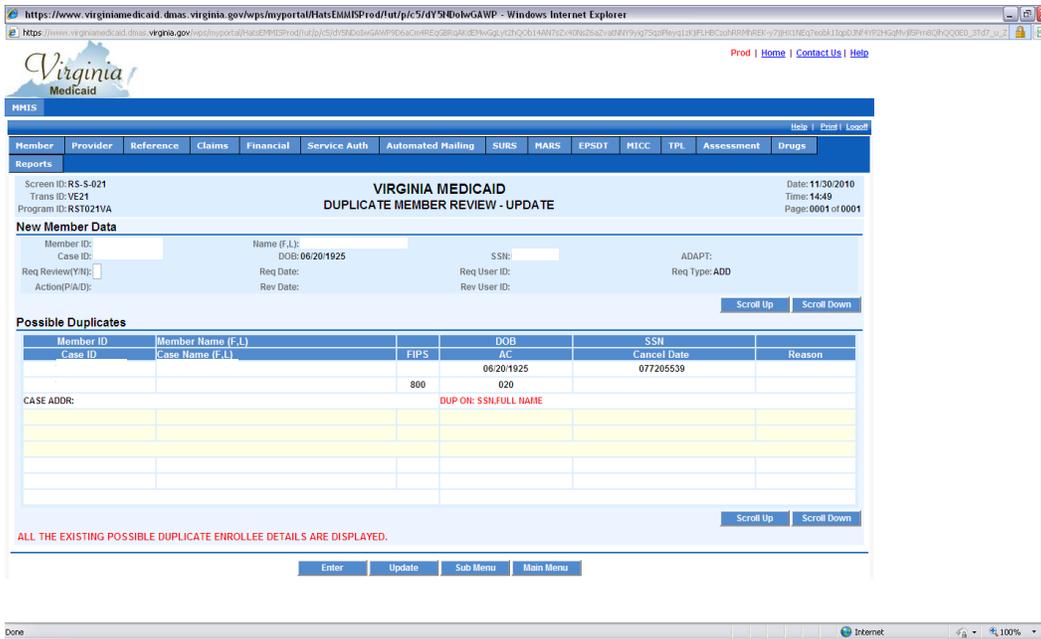


3. Click on the Enrollment radio button  
 4. Click "Sub Menu" to display the to display the Enrollment menu.

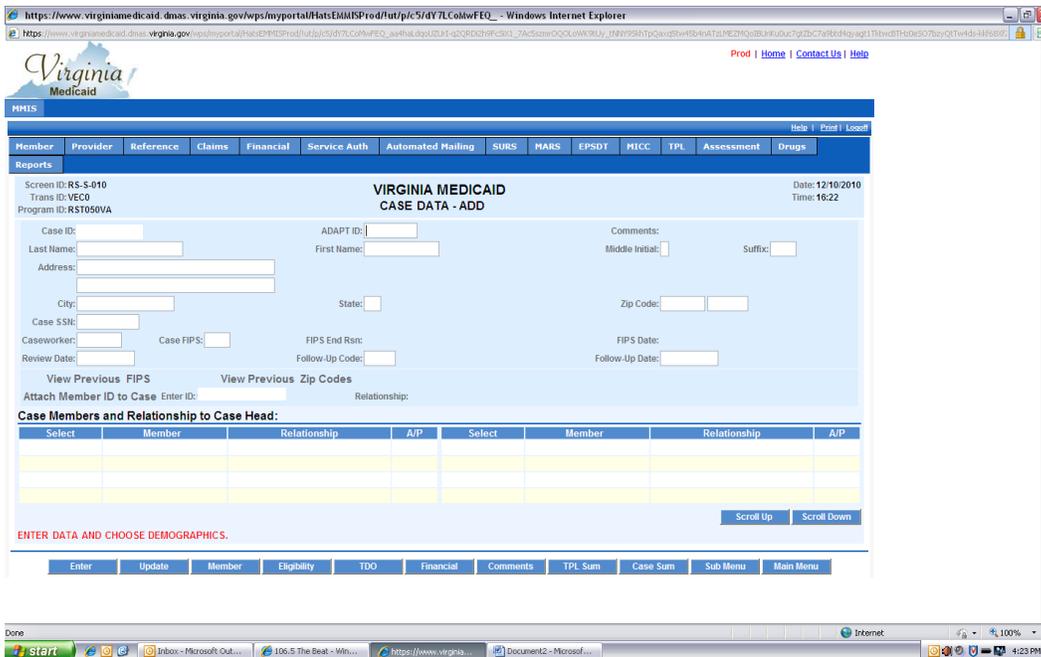
(screen RS-S-001)

5. Select Member type “Case and Member” and select Function “Add” and then enter the following information as shown below:
  - Case ID – Always enter 975.
  - Member ID – Always enter 975.
  - SSN – Enter member Social Security number from page 1 of the Assessment.
  - If a Social Security number is not provided, key “999”,two digit birthday month, 2digit day of birth and the last 2 digits of the birth year
  - Last Name - Enter member last name from page 1 of the assessment.
  - First Name – Enter member first name from page 1 of the assessment.
  - Date of Birth – Enter member date of birth from page 1 of the assessment.
  - Gender Form – Enter F for female, or M for male, from sex field on page 1 of the assessment.
6. Verify entries and then Click on the Enter button to display the Case Data – Add screen.
7. Dup Assessment Message
  - If “Dup Assessment” message is displayed in red at the bottom of the screen, verify Social Security number and Persons Name are the same.
  - Copy Member number from same line of Social Security number,
  - Write Member Number on top of Assessment form
  - If Social Security number does not match, key “Y” in the “Request Review” box at the top left side of the screen then print a copy of the screen and click “Enter”
  - Click “Update”
  - Submit screen print and Assessment to Team Lead for DMAS review

**(RS-S-021)**



(RS-S-010)



8. Enter Case data as shown in the example:

- Last Name – Member last name.
- First Name – Member first name.
- Address – Member address from screening form.
- Case SSN – Member Social Security number.

- Caseworker – Caseworker number – Enter your login number (A9999).
  - Case FIPS – Enter the City/County Code from the screening form.
  - Review Date – Enter the last day of the current month. For example, if the current date is 6/15/08, enter 6/30/2008.
  - Follow-up Code – Leave blank.
  - Follow-up Date – Leave blank.
9. Verify entries and then Click on the Enter button.
10. If no errors, click Demographics to update  
**(RS-S-018)**

Screen ID: RS-S-018  
Trans ID: VE18  
Program ID: RS1010VA

**VIRGINIA MEDICAID  
MEMBER DEMOGRAPHICS - INQUIRY**

Date: 12/18/2009  
Time: 15:47

Member ID: [redacted] P Last Name: [redacted] First Name: [redacted] MI: [redacted]  
Case ID: [redacted] ADAPT ID: [redacted] Caseworker: G800 Case FIP S: 670 Suffix: [redacted]  
Aid Category: 060 Benefit Plan: MEDICAID FFS More BP: N Exception Indicator: Absent Parent: N HIPP: [redacted] HIPP Status: [redacted] Comments: Y  
CMM Restriction Period: - CMM Restriction Status: [redacted] TPL: Y

Relationship to Case Head: 00 Gender: M DOB: [redacted] SSN: [redacted] Race: 1 Marital Status: U Primary Language: 1  
CIT Status: C CIT Level: [redacted] Identity: [redacted] CIT ID Date: [redacted] SSA Cit Ind: [redacted] Country: US Entry Date: [redacted]  
Same as Case Address: Y Same as Case FIP S: Y Mem FIP S: 670 EDD: [redacted] Infant Mother ID: [redacted] NRF: [redacted]  
Disability Code: [redacted] Disability Onset Date: [redacted] Special Ind: [redacted] DOD: [redacted]

Member Address: [redacted]  
City: [redacted] State: VA Zip Code: [redacted]

Card Date	Reissue Reason	Sequence #	Request #
07/15/2008	I	01	0

Suppress ID Card: N

View Member FIPS  View Previous Names  View Previous Address  View Aliases  View Health Conditions

Pend Claims: Begin Date: End Date: Pend Source:

**SELECT AN OPTION AND CHOOSE ENTER.**

Buttons: Enter, Update, MC Assign, Eligibility, TDO, Financial, Comments, Case, TPL Sum, ID X-Ref, Sub Menu, Main Menu, ID/CID, Dup Mem, BEINDEX, MICC, Absent Parent, VALTC Sum, Cost Eval, Case Sum

11. Enter data in the fields as shown below:
- Relationship to Case Head – Always enter “00”
  - Race – Enter the Race Code from the screening form – Always code “9”
  - Same as Case Address – Always enter “Y”
12. Same as Case FIPS – Always enter “Y”
13. Verify entries and then click the Enter button. If no errors, click on the Eligibility button to display the Eligibility Data – Add screen.  
**(RS-S-015)**

14. Enter data in fields as shown below:

- **Aid Category:**

Screen ID: RS-S-015  
 Tran ID: VER5  
 Program ID: RST016VA

**VIRGINIA MEDICAID  
 ELIGIBILITY DATA - REIN**

Date: 11/23/2009  
 Time: 18:53

Member ID: [REDACTED]  
 Name: [REDACTED]  
 Case ID: [REDACTED]  
 Caseworker: [REDACTED]

Case FIPS: 001

Consent Date: NO CONSENT  
 Plan First OR: 001  
 FPL% ST Begin Date: [REDACTED]  
 HIPP: [REDACTED]

Sel	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstatement Reason	Status
<input type="radio"/>	091	08 19 2008	08 01 2008	12 31 9999	003	05 31 2009	000	001	C
<input type="radio"/>	092	01 06 2000	01 01 2000	12 31 9999	016	05 31 2008	000	000	C
<input type="radio"/>	081	02 01 1999	02 05 1999	08 31 1999	025	08 31 1999	000	000	C
<input type="radio"/>	071	12 01 1998	12 01 1998	02 28 1999	099	02 05 1999	000	000	C
<input type="radio"/>	092	08 01 1997	08 15 1997	11 30 1998	003	11 30 1998	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	08 31 1997	099	08 15 1997	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	02 28 1993		02 28 1993	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	04 30 1990	003	04 30 1990	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	02 28 1990	012	02 28 1990	000	000	C
<input type="radio"/>	071	09 01 1989	08 01 1989	08 31 1989	011	08 31 1989	000	000	C

ALREADY AT THE TOP. SCROLLING NOT POSSIBLE.

Buttons: Enter, Update, Refresh, Member, TDO, Financial, Case, TPL Sum, Comment, Sub Menu, Main Menu, Cost Eval, Case Sum

- Enter 801 for Level 1 screening.
  - Enter 802 for Level 2 screening. If both Levels 1 and 2 were done, use 802.
  - Enter 803 for ALF (Assisted Living Facilities).
  - Application Date – Enter the date the screener signed the form.
  - Begin Date – Enter the date the screener signed the form.
  - End date – Leave blank. The system supplies the date.
15. Click Enter. If no errors, the system displays the Member Benefits screen to show the benefits approved for the member.

(RS-S-011)

Screen ID: RS-S-011  
Trans ID: VEC1  
Program ID: RST011VA

**VIRGINIA MEDICAID  
MEMBER BENEFITS - ADD**

Date: 12/10/2010  
Time: 16:26

Member ID: [Redacted]  
Name: [Redacted]  
Case ID: [Redacted]  
Caseworker: [Redacted]  
Case FIPS: [Redacted]

Comments:  
Income Less Than Or = 100% FPL:  
FPL % ST Begin Date:

Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Status	Extension Reason	Reinstate Reason
801	11/19/2010	11/19/2010	11/19/2010	080	11/19/2010	C		000

Benefit Plan	Exception Indicator	Plan Description	Provider ID	Begin Date	End Date	Change Source	End Reason	Disposition Ind	Disposition Date
08-00-1001		ASM NH LVL	000000000	11/19/2010	11/19/2010	DF	097	A	12/10/2010

DATA ADDED.

Enter Update Prov Loc Comments VALTC Sum Return Sub Menu Main Menu

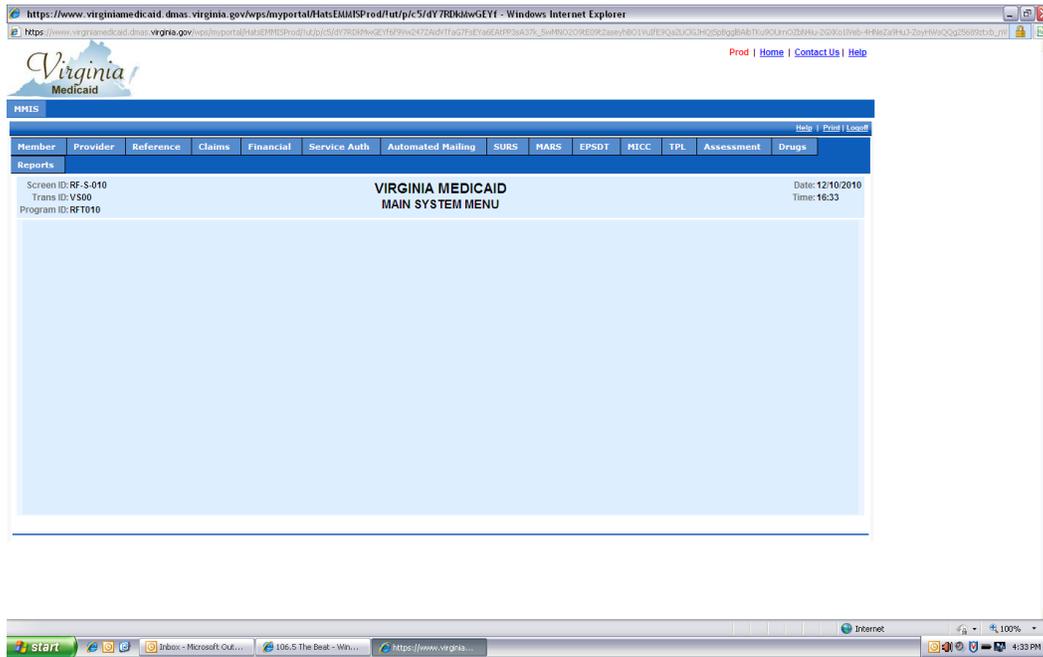
16. Verify the information entered. If there are errors, page back to the previous screen to correct the errors.
17. Click Update to post the data.
18. The screen is returned with the member ID number that has been assigned by the system.
19. Write the member ID number on the Assessment form and return to the Assessment screen to key the assessment. (Go to the Assessments procedures step 7)

## 2.2.6 Adding a New Eligibility Segment for Canceled Member

To add a new eligibility segment to the Enrollment File for a person who is on file but not eligible on the date of screening:

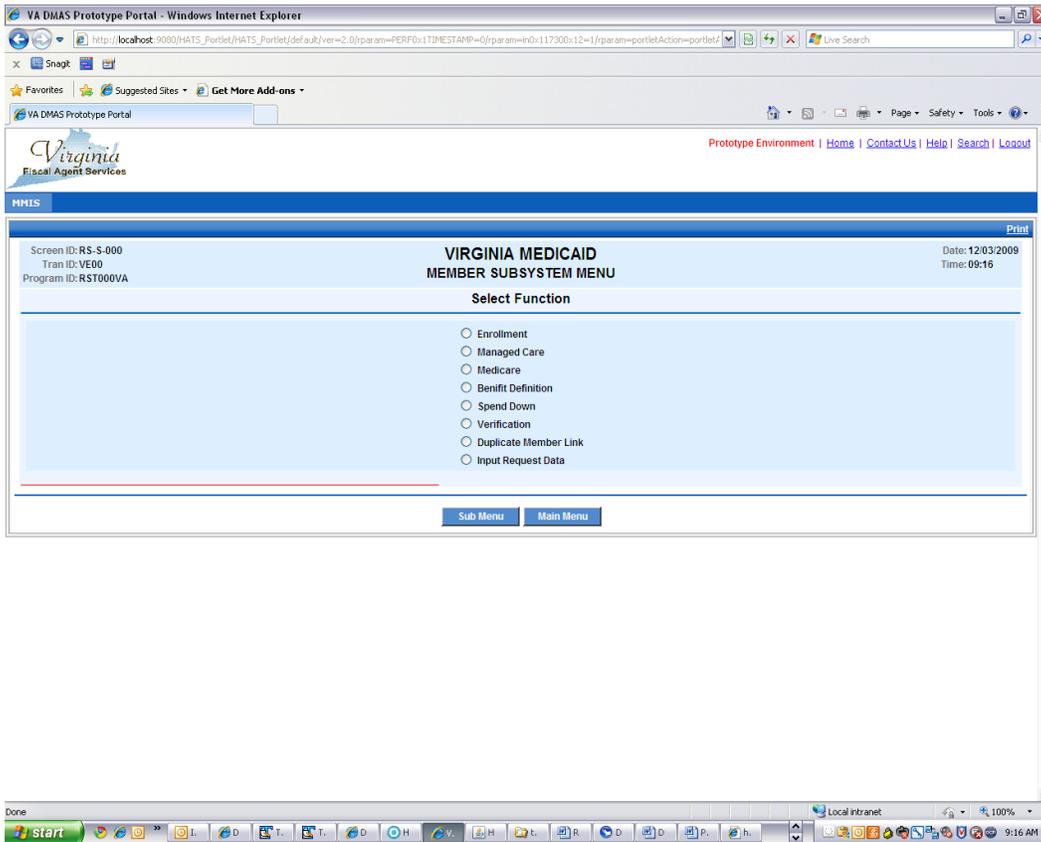
1. Access the MMIS Main Menu screen.

(RF-S-010)



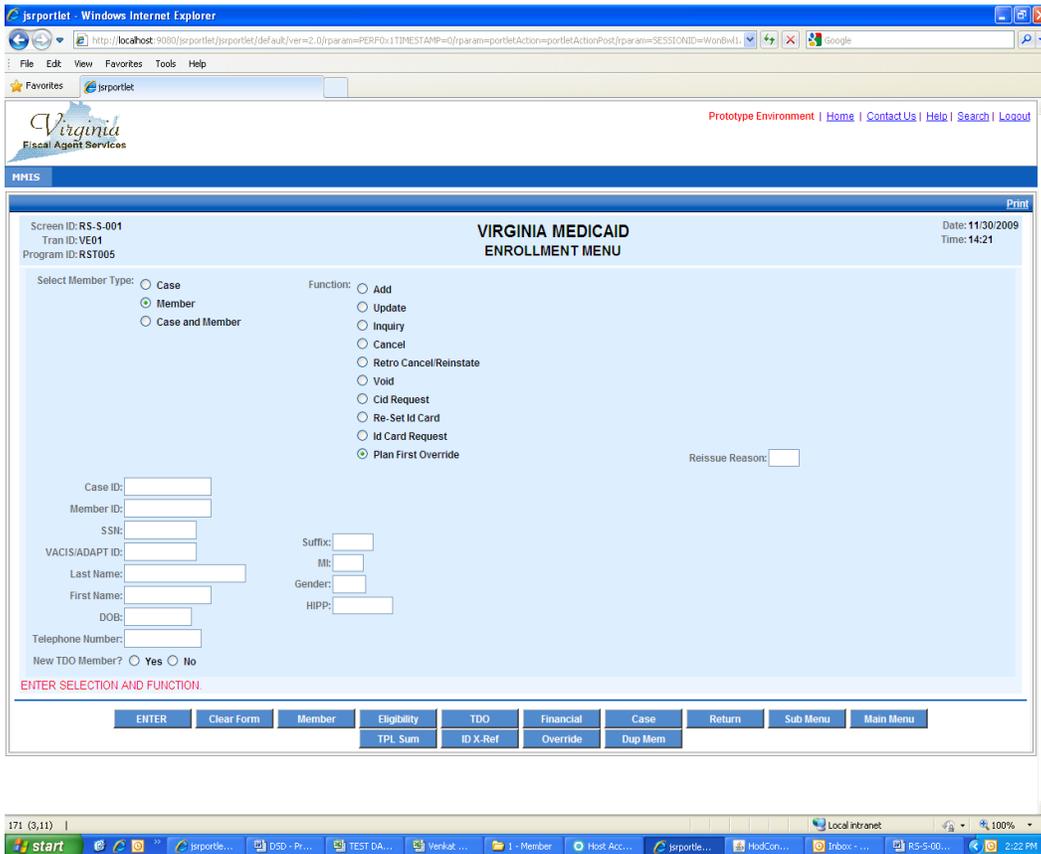
2. Click on the Member button to display the Member Subsystem menu.

(RS-S-000)



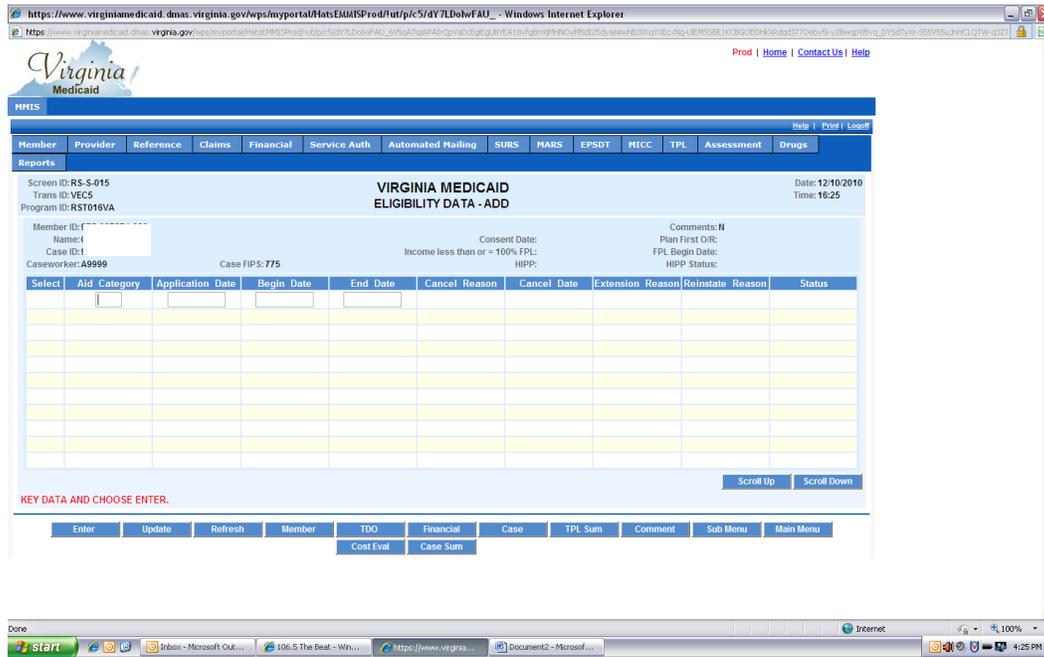
3. Click on the Enrollment radio button display the Enrollment menu.

(RS-S-001)



4. Select Member Type “Case and Member” and select the “Update” Function and enter the Member ID and then click the Enter button to display the Eligibility Data - Reinstatement screen.

(RS-S-015)



5. Enter data in fields as shown below:
  - Aid Category:
    - Enter 801 for Level 1 screening.
    - Enter 802 for Level 2 screening. If both Levels 1 and 2 were done, use 802.
    - Enter 803 for ALF (Assisted Living Facilities).
  - Application Date – Enter the date the screener signed the form.
  - Begin Date – Enter the date the screener signed the form.
  - End date – Leave blank. The system supplies the date.
6. Click on the Enter button. If no errors, the system displays the Member Benefits screen to show the benefits approved for the member.

## (RS-S-011)

Screen ID: RS-S-011  
Tran ID: VE11  
Program ID: RST011VA

Member ID: 1  
Name: [REDACTED]  
Case ID: [REDACTED]  
Caseworker: [REDACTED] Case FIPS: 059

Comments: N  
Income less than or = 100% FPL: Y  
FPL % ST Begin Date: 06 2008

Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Status	Extension Reason	Reinstatement Reason
092	09/06/2007	06/01/2008	12/31/9999	012	07/31/2009	C	000	000

Benefit Plan	Exception Indicator	Plan Description	Provider ID	Begin Date	End Date	Change Source	End Reason	Disposition Ind	Disposition Date
01-01-0100		MEDICAID FF	[REDACTED]	06/01/2008	07/31/2009	DF	097	A	05/17/2008
01-03-0802		XIX NORTHER	[REDACTED]	06/01/2008	07/31/2009	00	097	A	05/18/2008
01-01-0300		MED PREMIUM	[REDACTED]	06/01/2008	06/01/2008	00	097	V	05/17/2008
01-01-0400		MED CO & DE	[REDACTED]	06/01/2008	06/01/2008	00	097	V	05/17/2008

DATA DISPLAYED

Enter Update Prov Loc Comments VALTC Sum Return Sub Menu Main Menu

7. Verify the information entered. If there are errors, page back to the previous screen to correct the errors.
8. Click on the Update button to post the data.
9. Go to Assessments procedures step 7.

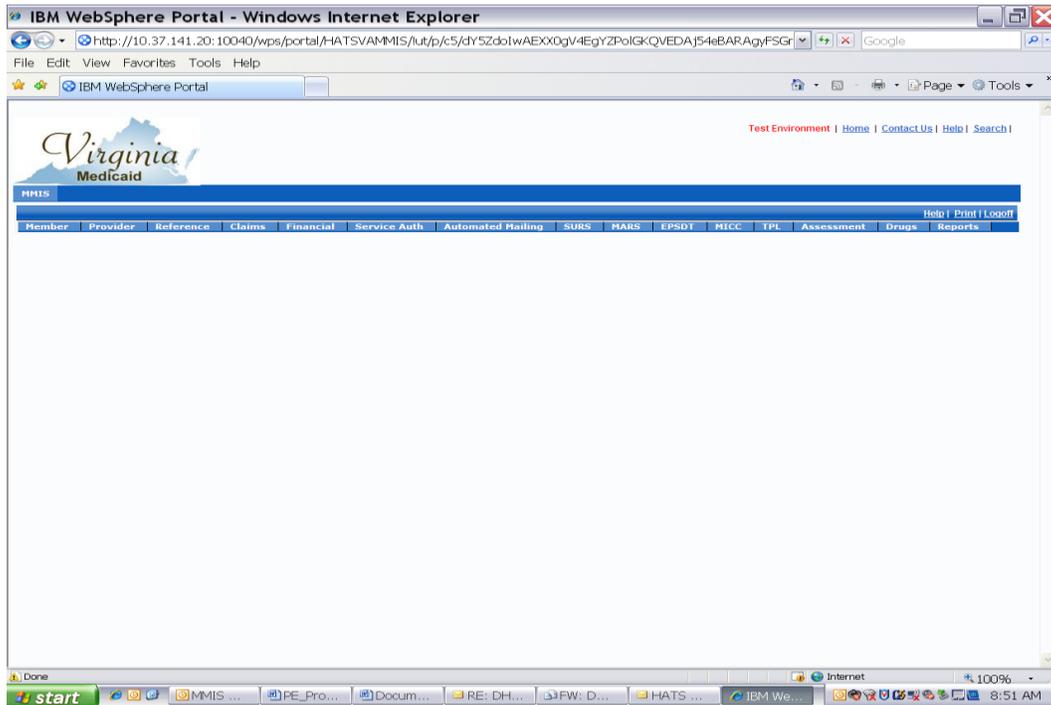
## 2.2.7 Changing a Member Record

If you see an error message Member **not Medicaid Eligible** or **Not Medicaid Eligible on the Day of Screening** while attempting to reinstate a member, follow the steps outlined below.

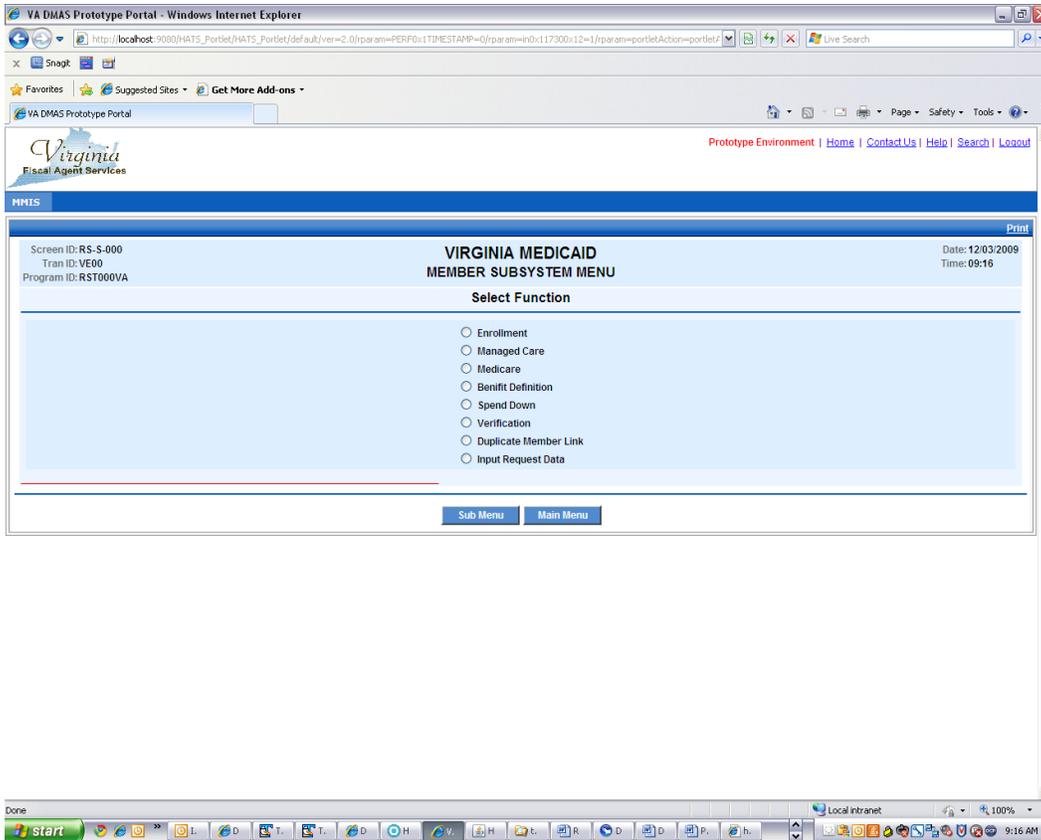
### Procedure:

1. Access the MMIS Main Menu screen.

(RF-S-010)

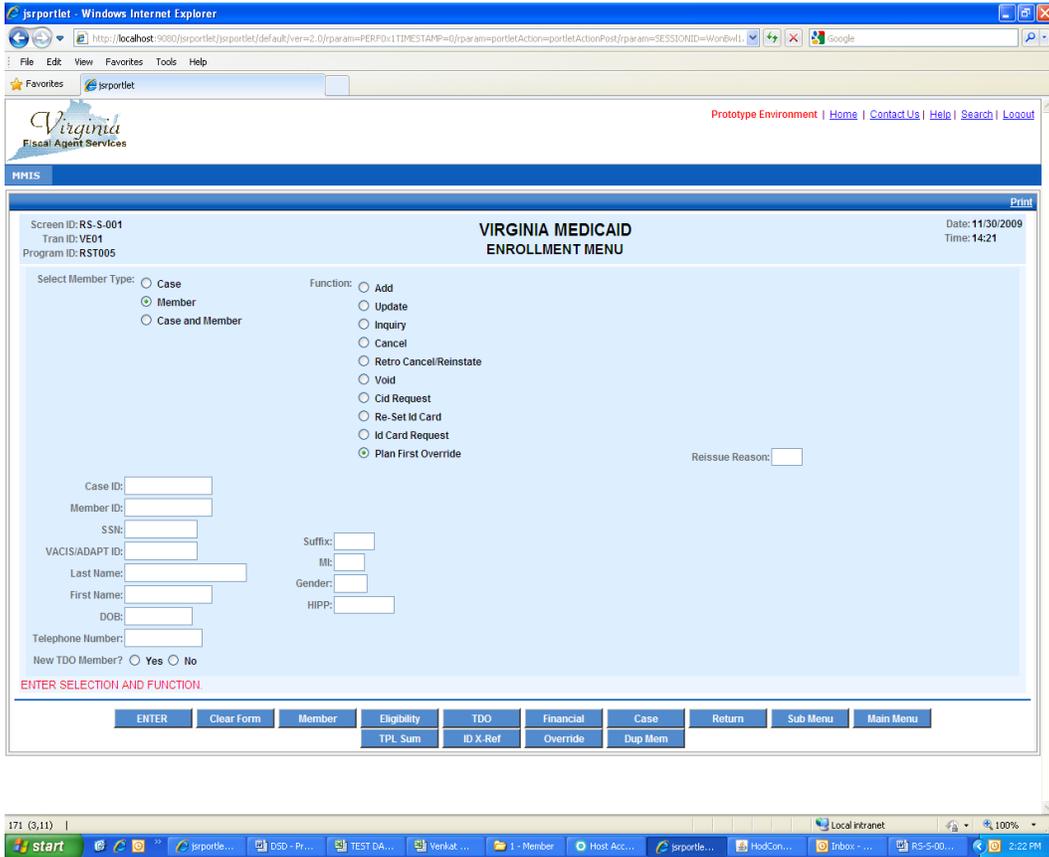


2. Click on the Member button to display the Member Subsystem menu.



3. Click on the Enrollment radio button to display the Enrollment menu.

(RS-S-001)



4. Review the DMAS-96 form for the Member Medicaid ID or Social Security Number.

If	Then
There is a Member Medicaid ID on the DMAS-96 form,	Click on the box next to the Member <b>ID</b> field. Choose <b>Enter</b> , and then go to Step 5 below.
There is no Member Medicaid ID on the DMAS-96 form,	Do not select anything in the <b>Select Function</b> box. Key in the Social Security number or last name and first name. Click Enter. If the record is found, go to Step 5 below.

5. Select Enrollment Type “Member” and Function “Update” and enter the Member ID in the member ID field and then click on the Enter button.

6. Click on the Eligibility button to display the Eligibility Data Update screen.

(RS-S-015)

Screen ID: RS-S-015  
Tran ID: VERS  
Program ID: RST016VA

**VIRGINIA MEDICAID  
ELIGIBILITY DATA - REIN**

Date: 11/23/2009  
Time: 18:53

Member ID: [REDACTED]  
Name: [REDACTED]  
Case ID: [REDACTED]  
Caseworker: [REDACTED]  
Case FIPS: 001

Consent Date: NO CONSENT  
Income Less Than Or = 100% FPL:  
HIPP:

Comments: N  
Plan First OIR:  
FPL% ST Begin Date:  
HIPP Status:

Sel	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstatement Reason	Status
<input type="radio"/>	091	08 19 2008	08 01 2008	12 31 9999	003	05 31 2009	000	001	C
<input type="radio"/>	092	01 06 2000	01 01 2000	12 31 9999	016	05 31 2008	000	000	C
<input type="radio"/>	081	02 01 1999	02 05 1999	08 31 1999	025	08 31 1999	000	000	C
<input type="radio"/>	071	12 01 1998	12 01 1998	02 28 1999	099	02 05 1999	000	000	C
<input type="radio"/>	092	08 01 1997	08 15 1997	11 30 1998	003	11 30 1998	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	08 31 1997	099	08 15 1997	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	02 28 1993		02 28 1993	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	04 30 1990	003	04 30 1990	000	000	C
<input type="radio"/>	071	09 01 1989	09 01 1989	02 28 1990	012	02 28 1990	000	000	C
<input type="radio"/>	071	09 01 1989	08 01 1989	08 31 1989	011	08 31 1989	000	000	C

ALREADY AT THE TOP. SCROLLING NOT POSSIBLE.

Buttons: Enter, Update, Refresh, Member, TDO, Financial, Case, TPL Sum, Comment, Sub Menu, Main Menu, Cost Eval, Case Sum

7. Enter data in the Aid Category field as shown below;
  - Enter 801 for a Level 1 screening.
  - Enter 802 for a Level 2 screening.
  - Enter 803 for an ALF (Assisted Living Facility) ACR.
  - In the Application Date field, enter the date the screener signed the form.
  - In the Begin Date field, enter the date Screener signed the form.
8. Click on the Enter button.
9. Click on the Update button.
10. Go to Assessments procedure step 7.

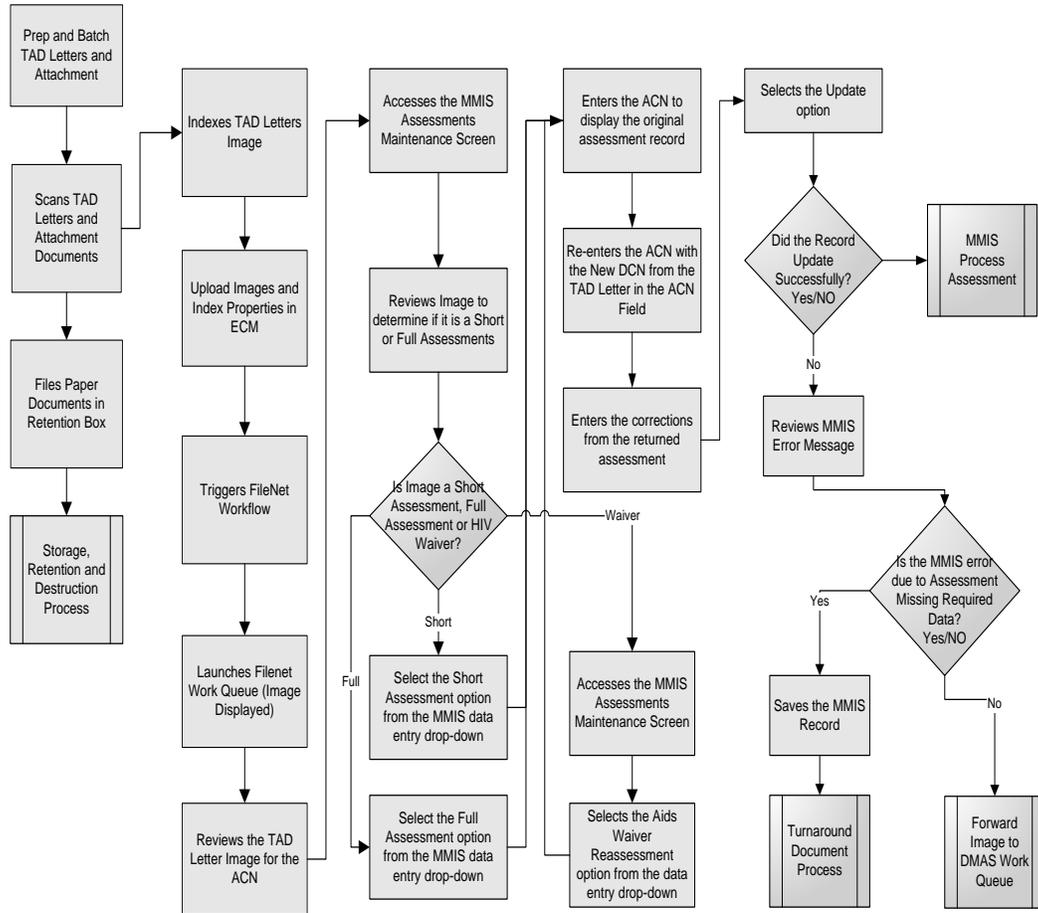
## 2.3 Turnaround Documents (TADs)

When an Assessment is keyed, the system edits the data entered for completeness and validity. If the document is not approved because certain data is missing or invalid, or is a possible duplicate, the system suspends the Assessment and automatically generates a TAD Cover Letter asking the provider to correct the fields in error. The operator sees a message that indicates the Assessment is being pended and that a TAD cover letter is

being generated. The Assessment Packet is then sent to the provider with the TAD cover letter that prints the following day. When the provider returns the corrected Assessment, the operator accesses the pending record online and enters only those fields that have been corrected by the provider.

### 2.3.1 Turnaround Document (TAD) Process Workflow

This diagram presents a graphic depiction of the document preparation, scanning, and data capture processes.



### 2.3.2 Turnaround Document Data Entry Procedures

The returned TAD Assessment documents are keyed into the pending Assessment record. The operator accesses the record using the Member ID.

**🕒 SLA (Service Level Agreement): Process TADS ≤ 5 days working days from receipt and data entry accuracy 100%**

**Procedure:**

1. From the Main System menu, click on the Assessments Subsystem button to display the Assessment Maintenance Menu screen.

**(AS-S-005)**

The screenshot shows a web browser window displaying the 'VIRGINIA MEDICAID ASSESSMENT MAINTENANCE MENU'. The page includes a header with the Virginia Medicaid logo and navigation links. The main content area contains several input fields: SSN, Last Name, First Name, MI, Suffix, Member ID, and Assessment Date. Below these fields is a section titled 'Select Data from Data Entry Functions, Browse Functions or Maintenance Functions' with three dropdown menus. A 'Select Function' section follows, featuring radio buttons for 'Add', 'Change', 'Inquiry', and 'Delete'. At the bottom of the form are buttons for 'Enter', 'Clear Form', 'Return', 'Sub Menu', and 'Main Menu'. The browser's address bar shows a URL with various parameters, and the taskbar at the bottom indicates the system time as 11:27 AM on 01/14/2010.

2. Enter the Member SSN or Member ID and the Assessment Date
3. Review the TAD document attachment and determine if it is a Short Assessment or Full Assessment
4. In the Assessment Maintenance Menu, Select the appropriate option from the Data Entry Functions drop-down box then click on the Change radio button and then click on the Enter button
5. Type New ACN located on the back of the TAD Cover Letter
6. Locate the fields on the TAD Cover Letter that are in error status.
7. Key the corrections from the corrected document.
8. Click Enter after each page to lock in corrected changes
9. Once all changes have been made, click Update
10. If there are still fields in error, accept the record and allow it to pend and follow prompt noted at the bottom of the screen.

# 3 Claims Resolution Procedures

During mainframe processing, validity edits and history audits cause payment requests with errors to be suspended for review by █████ and/or DMAS staff. Pended claims are automatically routed by the system to pend locations at both █████ and DMAS. Locations are listed below. Locations in **bold** are transfer locations only, meaning that claims are not automatically assigned to them.

Number	Location Name
001	Budget Pend Recycle
002	Financial Pend
100	█████ Claims Resolution (Easy)
200	█████ Claims Resolution (Complex)
217	Special Batch Pends, Contract Monitor Review
218	Payment Processing Manager
219	Contract Monitor
221	Pricing/DMAS
225	Capitation Payments
230	Medallion Management Fees
<b>250</b>	<b>█████ Claims Resolution (Supervisor Review)</b>
300	HUR General Claims Receipt
308	SLH - Hospital
310	SLH – Physician
312	ER – Hospital
313	CMM Claims
314	ER – Physician
317	Non-Resident Aliens
319	TDO – Physician
320	TDO – Hospital
321	DMAS Medical Consultant
333	Out of State Hospitals
400	Medical Support - Professional Consultant Pharmacy Consultant (Dental, PA, 0148) 407
<b>600</b>	<b>Recycle by System</b>
<b>650</b>	<b>Pend for Requested Information</b>

Number	Location Name
700	Pre-authorization
<b>750</b>	<b>Electronic and Direct Data entry attachment “park” location</b>
800	Post Payment Review
900	DMAS TPL

The Claims Services Operations Pend Resolution Unit is authorized to resolve pended claims in Locations 100, 200, and 250 and has transfer authority for Locations 250, 650, 750, and DMAS locations. Claims are routed to the location with highest priority. For instance, Location 200 requiring complex resolution receives the pended claim before Location 100 (easy resolution). Claims are retrieved online, by claim number, according to oldest pended claim first. Within each pend location, as each pend is resolved and entered back into the claims processing system; the next pended claim is presented. This means that if three (3) people sign-on to Location 100, the first person is presented with the oldest claim in Location 100, the next person is presented with the second oldest claim, and the third person is presented with the third oldest claim. Whoever finishes a claim first is presented with the next oldest claim for that location, and so on. The same pended claim cannot be called to more than one (1) workstation at the same time.

As each pended claim is presented, the operator can retrieve the corresponding claim image stored on the image retrieval system at the same time providing staff with a paperless image of the original claim for comparison with the online claim record. If the claim or a conflicting claim predates the imaging process, the operator obtains a copy of the claim or conflicting claim for review. Resolution staff should work all location pends for which they are authorized. After resolution, the claim is re-entered into the system. If more errors are encountered, the system pends the claim again and routes it to the next appropriate location. Each subsequent pend condition is resolved and re-entered until the claim is either paid or denied.

Pended claims are reviewed and resolved according to policy and guidelines approved by DMAS. Each edit is first researched in the online Edit/Audit Manual, which contains the edit description and instructions for resolution. Resolution is implemented via the appropriate online screen.

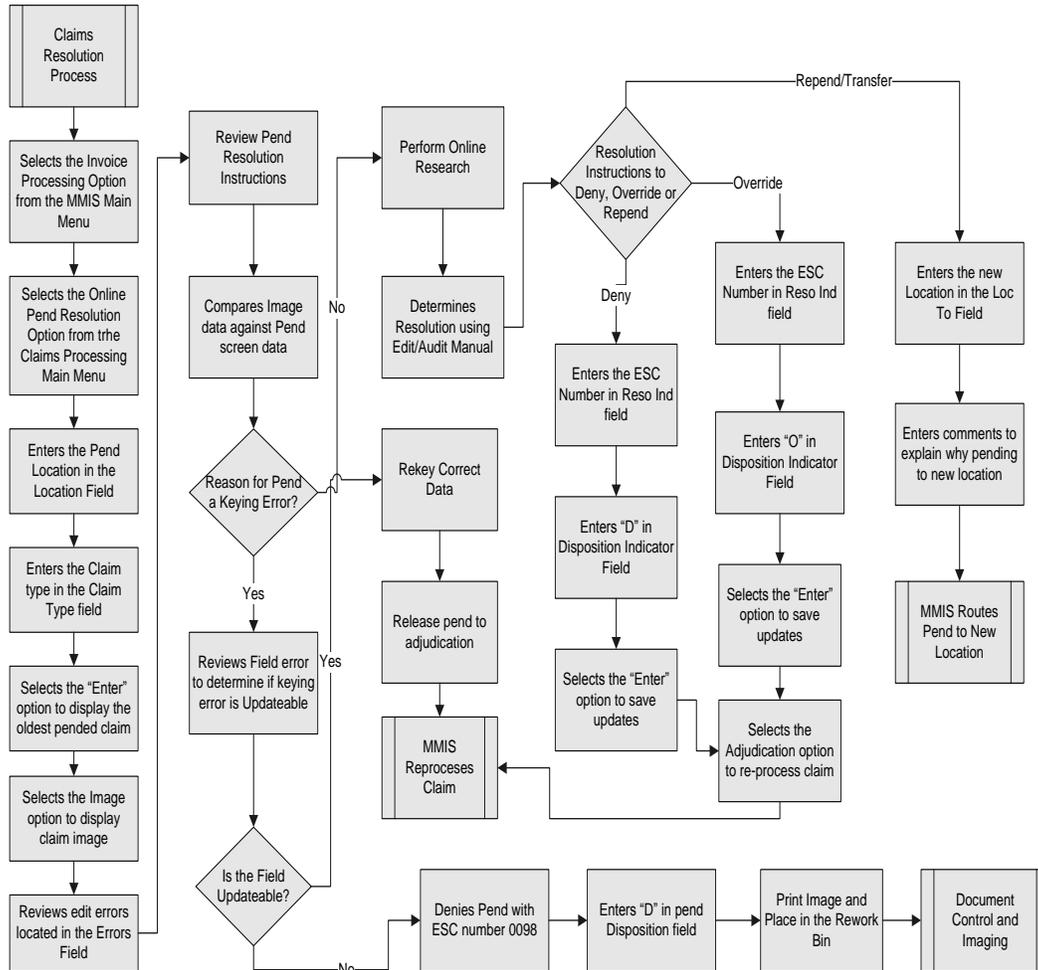
Pend Resolution staff retrieve electronic claims/claim images individually online for each pended claim presented on the relevant Pend Resolution screen. Once resolution is determined, the claim may be corrected, overridden, denied, or re-pended to the Resolution Supervisor for further review or to DMAS for medical review.

If keying errors are found in the course of resolving pend, the operator corrects the error if the error is in an unprotected field. If the error cannot be corrected and it was a paper submitted claim identified with a media code of 3 or 4, the payment request is denied using Error Code 0098, and the payment request must be re-imaged and re-keyed in data entry.

While pends are presented for resolution in date order, it is possible that pends may not be resolved timely resulting in aged pends. These pends are listed on aged pend reports (30, 60, 90, or 180 days) which are used by Pend Resolution staff to retrieve and resolve specific claim records. Such claims can be retrieved individually by Provider ID, claim type, or ICN.

# 3.1 Claims Resolution Process Workflow

This diagram presents a graphic depiction of the Claims Resolution process.



# 3.2 Accessing Suspended Payment Requests and Image

The Online Pend Resolution Master Menu (CP-S-001-02) provides access to the pend resolution screens needed by the Pend Resolution Unit. The fields on this menu (Location, ICN, Billing Provider ID, Claim Type, and ESC Edit) allow Resolution staff to select either pended claims for sequential resolution, oldest claim first by location, or specific claims for resolution.

The Location and Claim Type are required entries. If no other field is entered, and the Enter button is chosen, the oldest pended claim is automatically presented on the screen. Otherwise, staff has the option of entering any other field to call a specific claim number, claim type, billing provider, or ESC Edit. If a ten-digit, number is entered in the Billing Provider ID, only NPI claims are displayed. If field is left blank, Legacy and NPI are displayed. If Location is entered, but the user is not authorized to access that location, a screen error message displays.

Once a pended payment request is retrieved using the menu, the payment request is presented on one of several different screen formats according to the type of invoice used to bill the service. These screens are presented in the sections that follow in this manual.

## 3.3 Navigation

Navigation buttons at the bottom of the **Pend** screens allow the operator to access various other screens to assist in research. Most screens have the following navigation buttons:

- **Enter** – Edits the entries and presents system error/information messages.
- **Member** – Takes the user to the Member Subsystem.
- **Provider** – Takes the user to the Provider Subsystem.
- **Procedure** - Takes the user to the Procedure Code Table.
- **CHIRP** – Takes the user to the Claims History Information Retrieval Processor.
- **Edit Text** – Takes the user to the Error Text Table.
- **Comment** – Takes the user to the screen used to enter comments and remarks about the resolution or disposition of the pended claim.
- **Consent** – Takes the user to the screen used to enter consent data.
- **Service Auth** – Takes the user to the Prior Authorization menu.
- **Conflict Claims** – Takes the user to the Pend Resolution Conflicting Claims (CP-S-001-09) screen.
- **Clear Form** – Clears all the data entered in the screen and allows the user to enter new data.
- **Diagnosis** – Takes the user to the Diagnosis Code Table.
- **Refresh** – Displays the last updated information (if any) from the database.
- **Revenue** – Takes the user to the UB Claim Revenue Data (CP-S-001-04) screen (UB screen only).
- **Adjudication** – Submits the claim to the adjudication process.
- **Image** – Displays an image of the pended payment request.
- **Attach** – Displays an image of the Claim Attachment Form and its attachments.
- **Value Code** – Takes the user to the Value Code Table (CP-S-008-13) (UB screen only)

### Procedure:

1. From the Claims Processing Main Menu, click on the Pend Resolution Menu radio button from the selections listed to display the Online Pend Resolution menu (CP-S-001-0101).
2. When the Online Pend Resolution Menu (CP-S-001-02) displays, key your authorized pend location in the Location field and enter the claim type in the claim type field and choose Enter. The oldest pended claim for your location displays on the screen.
3. Choose the Image button to access the corresponding claim image.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>

### 3.3.1 UB-04 Resolution Procedures

The UB Claim Online Pend Resolution screen (CP-S-001-03) displays codes for errors that caused a payment request submitted on a UB invoice to pend. Because the UB document contains a large volume of data, this screen contains only part of the UB data. The remainder of the UB data is maintained on the UB Claim Revenue Data Online Pend Resolution screen (CP-S-001-04) and the Value Code Screen (CP-S-008-13). From this screen, other screens can be accessed for additional data entry or data inquiry by choosing one of the navigation buttons at the bottom of the screen:

#### **SLA (Service Level Agreement): Process Suspended Claims in ≤ 30 days from original pend date**

##### **Procedure:**

1. On the Online Pend Resolution Menu (CP-S-001-02), enter your location code in the Location field.
2. Enter the claim type code in the Claim Type field.
3. Click the Enter button to display the first pended UB claim for the selected claim type displays on the Online Pend Resolution screen (CP-S-001-03).
4. Begin working the first error code displayed in the Errors field for which you are authorized to resolve.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Member	Provider	Reference	Claims	Financial	Service Auth	Automated Mailing	SURS	MARS	EPSDT	MICC	TPL	Assessment	Drugs
<b>Reports</b>													
Screen ID: CP-S-001-03 Trans ID: VH15 Program ID: CPA114VA													
<b>VIRGINIA MEDICAID</b> <b>ONLINE PEND RESOLUTION --UB CLAIM--</b>													
Date: 06/28/2013 Time: 15:38													
ICN: [REDACTED]	Att Ind: N	Claim Type: 01	Modifier: 1	User ID: [REDACTED]									
LOC-From: 333 To [REDACTED]	Status: 4	From Date: 11/28/2012	Thru Date: 12/02/2012	Former ICN:									
TAD#: [REDACTED]	NTP: 001	Adj Reason:	FCN:	Life Threatening: N									
Payment Days: 0004	Pend Reduce: 0000	Cutback Days: 0000	Covered Days: 0004	Non-Covered Days: 0000									
Reso Ind: [REDACTED]				Admt Date: 11/28/2012									
Attach #: [REDACTED]													
Errors: 0835 p													
Hour: 01													
Member ID: [REDACTED]	Name: [REDACTED]	DOB: [REDACTED]	Gender: F										
Provider ID: [REDACTED]	Name: [REDACTED]	Provider Type: 001											
Attending: [REDACTED]	Other1: 0000000000	Other2: 0000000000	Zip Code: [REDACTED]										
Srv Auth#: [REDACTED]	Consent: N	Copay Ind: N	Manual Price: 0.00										
COB Code: 82	TPL Ind: N	Discharge Status: 01	TPL Amount: 0.00										
Type of Bill: 111	ACC Ind: N	Eligible Days: 000	Patient Pay Amount: 0.00										
Admit Type: 3	LOA Days:	Employment Ind: N	Private Room Differential: 0.00										
Determined Version: 9	MCARE Paid Amt:	Tentative Payment: 0.00											
Diagnosis Code: 29690	29690	30981	31401	31381	317	V618	V623						
Procedure Code/Date:													
UPDATE DATA AND CHOOSE ENTER.													
Enter	Clear Form	Refresh	Image	Split Image	Attach	Member	Provider	Return	Sub Menu	Main Menu			
Procedure	Edit Text	Comments	Adjudication	Consent	Service Auth	Conflict Claims	Diagnosis	Revenue	Value Code	CHIRP			

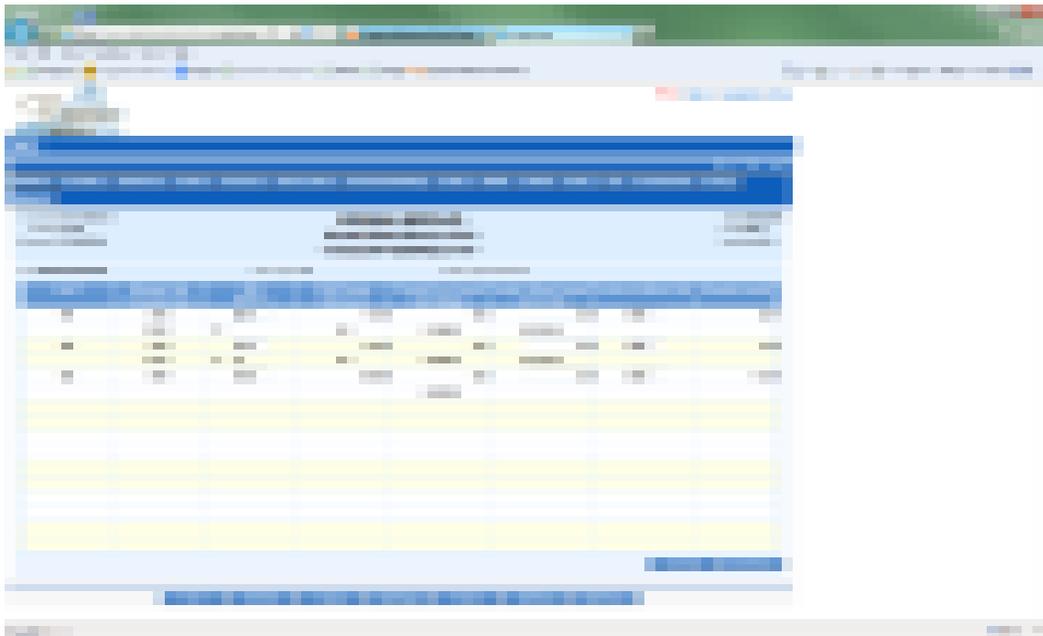
### 3.3.2 UB-04 Payment Request Revenue Data

The UB Claim Revenue Data screen (CP-S-001-04) is the screen that displays revenue code/unit data for the pending UB payment request. Once information is reviewed or updated, clicking on the Enter button at the bottom of the screen edits the entered data. Resolution staff can return to the UB Claim Online Pend Resolution screen (CP-S-001-03) and continue or complete the resolution process.

#### Procedure:

1. If appropriate to the resolution, enter changes in the appropriate field(s) and choose Enter to edit the entry(ies).
2. Click on the Return button to return to the first UB Claim Online Pend Resolution screen (CP-S-001-03) and continue or complete the resolution process.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

(CP-S-001-04)



### 3.3.3 UB-04 Payment Request Value Codes

The UB Claim Value Code Online Pend Resolution screen (CP-S-008-13) is the screen that displays value code data for the pending UB payment request. Resolution staff can return to the UB Claim Online Pend Resolution screen (CP-S-001-03) and continue or complete the resolution process.

**Procedure:**

1. Click on the Return button to return to the first UB Claim Online Pend Resolution screen (CP-S-001-03) and continue or complete the resolution process.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.



Member	Provider	Reference	Claims	Financial	Service Auth	Automated Mailing	SURS	MARS	EPSDT	MICC	TPL	Assessment	Drugs	Reports
Screen ID: CP-S-001-05														Date: 06/28/2013
Trans ID: VH11														Time: 15:40
Program ID: CPA112VA														Page: 01 of 01
<b>VIRGINIA MEDICAID</b>														
<b>ONLINE PEND RESOLUTION --1500 CLAIM--</b>														
ICN: [REDACTED]	Claim Type: 05	Claim Type Modifier: 1	User ID: [REDACTED]											
Loc From: 100	To: [ ]	Status: 4	From Date: 12/10/2012	Thru Date: 12/10/2012										
TAD#: [ ]	NTP: 001	Attachment Ind: N	Adj Reason:											
FCN: [ ]	Former ICN:	Life Threatening: N												
Attach#: [ ]														
Reso Ind: [ ]														
Errors: 0740 P														
Member ID: [REDACTED]	Name: [REDACTED]	DOB: [REDACTED]	Gender: F											
Provider ID: [REDACTED]	Name: [REDACTED]	Provider Type: 020												
Referring: 0000000000	Billing: [REDACTED]	Zip Code: [REDACTED]												
Service Auth #: 0000000000	Consent Ind: N	Copy: N	Manual Price: 0.00											
COB Code: 3	Type of Service: 5	TPL Ind: Y	TPL Amount: 22.78											
Cutback Days/Units: 0000	Place of Treatment: 11	ACC Ind: N	Tentative Payment: 0.00											
FIPS: 003	Unit/Visit/Study: 0001	FP Ind: N	Billed Charges: 42.00											
Wait/Anes Min: 0000	# of Passengers:	EMP Ind: N	Allowed Charges: 15.75											
Mileage: [ ]														
Procedure Code: 87804	Modifier: [ ]	Determined Version: 9												
Diagnosis Code Primary: 07999	Secondary: [ ]	Other: [ ]												
UPDATE DATA AND CHOOSE ENTER.														
Enter	Clear Form	Refresh	Image	Split Image	Attach	Member	Provider	Procedure	Return	Sub Menu	Main Menu	Edit Text	Comments	Adjudication
					Consent	Service Auth	Conflict Claims	Diagnosis	CHRP					

## 3.5 Crossover Payment Request

The Crossover Online Pend Resolution screen (CP-S-001-06) or (CP-S-001-03) are the screens that displays pending payment requests for Medicare Crossover services billed on the UB04 (CP-S-001-03) or CMS1500 (CP-S-001-06) invoice. Once information is reviewed or updated, clicking on the Enter button at the bottom of the screen edits the entered data.

### SLA (Service Level Agreement): Process Suspended Claims in ≤ 30 days from original pend date

#### Procedure:

1. On the Online Pend Resolution Menu (CP-S-001-02), enter your location code in the Location field.
2. Enter the claim type code in the Claim Type field and click the Enter button.
3. The first pended Crossover claim displays on the Online Pend Resolution screen (CP-S-001-06 or (CP-S-001-03).
4. Begin working the first error code displayed in the Errors field for which you are authorized to resolve.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

(CP-S-001-06)

Screen ID: CP-S-001-06  
Trans ID: VI023  
Program ID: CPA118VA

**VIRGINIA MEDICAID**  
ONLINE PEND RESOLUTION - TITLE XVIII CLAIM--

Date: 03/05/2015  
Time: 08:38  
Page: 01 of 01

ICR: [REDACTED] Claim Type: 09 Modifier: 1 User ID: XA247  
Status: 4 From Date: 06/10/2014 Thru Date: 06/10/2014  
Loc From: 200 To: [REDACTED]  
TADR: [REDACTED] Former ICR: [REDACTED] Attachment Ind: N Adj Reason:  
FCIL: [REDACTED] ITP: 001 Medicare Coverage: B Admit Date:  
AtchR: [REDACTED]

Reso Ind: [REDACTED]

Errors: 0978 P

Member ID: [REDACTED] Name: [REDACTED] DOB: 01/13/1964 Gender: F  
Provider ID: [REDACTED] Name: [REDACTED] Provider Type: 020 Zip Code: [REDACTED]

Unit/Visit/Study: 0001	Copy: A	Medicare Charges: 154.00	Manual Price: 0.00
COB Code:	TPL Ind: Y	Medicare Allowed: 104.88	TPL Amount: 0.00
Place of Treatment: 11	Emp Ind: N	Medicare Paid: 58.88	Tentative Payment: 0.00
Type of Service: 1	ACC Ind: N	Medicare Deductive: 0.00	Patient Pay Amount: 0.00
Emergency Ind: N	Coin Ind: [REDACTED]	Medicare Coinsurance: 0.00	Ans Min: 0000
Procedure Code: 99203	Modifier: [REDACTED]	Medicare Copay: 45.00	NDC: [REDACTED]

UPDATE DATA AND CHOOSE ENTER.

Enter	Clear Form	Refresh	Image	Split Image	Attach	Member	Provider	Return	Sub Menu	Main Menu
Procedure	Edit Text	Comments	Adjudication	Consent	Conflict Claims	CHBP				

(CP-S-001-03)

## 3.6 Online Pend Resolution Procedures

Resolving pended payment requests is an online function that does not require the use of paper pend lists, wrappers, or pend sheets. All steps in the resolution process are performed online.

### **SLA (Service Level Agreement): Process Suspended Claims in ≤ 30 days from original pend date**

#### Procedure:

1. From the Virginia Medicaid Main System Menu, click on the Claims button to display the Claims Processing Main Menu (CP-S-001-01).
2. Click on the Pend Resolution Menu radio button from the selections listed on the Claims Processing Main Menu.
3. When the Online Pend Resolution Menu (CP-S-001-02) displays, key the authorized pend location in the Location field and Claim Type and then click the Enter button. The oldest pended claim for that location is displayed on the screen.
4. Click the Image button to access the corresponding claim image.
5. Begin with the first error code displayed in the Errors field that you are authorized to resolve. If a keying error in a protected field caused the error, deny the claim by entering Error Code 0098 in the first four-character field of the Reso Ind field set, then enter D in the one-character field directly beside the code. Refer to Section 3.7.2 - Resolve Keying Errors for further instructions on keying errors.
6. If there are no keying errors, begin the resolution process by researching the error code online. Refer to Section 3.7.1 - Determine Resolution Using Edit/Audit Manual for instructions.
7. As you enter corrected data into the appropriate fields, choose Enter to edit the data. You may edit each changed field individually, or wait until all fields have been entered, and choose Enter to edit them one (1) time. Fields in error are highlighted for re-entry.
8. If the resolution instructions are to deny the payment request, do so by entering the four-character ECS number (the number displayed in the Errors field) in the Reso Ind field and D in the Disposition Indicator field which is the one-character field that follows each Reso Ind field.
9. If the resolution instructions are to override the edit, do so by entering the four-character ECS number (the number displayed in the Errors field) in the Reso Ind field and O in the Disposition Indicator field which is the one-character field that follows each Reso Ind field.
10. If the resolution instructions are to re-pend the payment request, do so by entering the three-character new location code in the Loc To field that follows the Loc From field. If you transfer a payment request to another location, you must enter remarks on the Online Pend Resolution Comment Entry screen (CP-S-001-10) to explain why you are sending pend to the new location. Refer to Section 3.6.5 - Enter Online Pend Resolution Comments for instructions.

11. When all fields in error have been corrected or you have entered deny, override, or new location, click on the Adjudication button to re-enter the claim into the processing system.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system. For resolution instructions for each error code, refer to the Edit/Audit Manual, which can be accessed through the online Help website at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>.

### 3.6.1 Determining Resolution Using Edit/Audit Manual

The Virginia MMIS Online Documentation Library contains the Edit/Audit Manual. The library is accessible through the Help component available on the toolbar at the top of the screen page. The Edit/Audit Manual contains a description of each edit (in ascending numeric order), identifies the cause of the error condition and the data field affected, and provides instructions for correcting the error or for otherwise resolving the pend. Instructions are provided only for errors that are set to pend to █████ Claims Services Operationspend locations.

#### Procedure:

1. Click on Online Help in the toolbar at the top of your screen. Choose Online Help from the dropdown menu to retrieve the Virginia MMIS Online Documentation Library.
2. Click on Edit/Audit Manual to display a list of error codes in ascending numeric order.
3. Each error has been assigned an Edit number and an ESC number. The Edit number is the code that was in the old system. The ESC number is the Edit Sequential Code. Most edits have the same number for both the Edit number and the ESC number. Many of the combination edits and duplicate edits have multiple ESC numbers assigned to each Edit number to separate specific criteria. The Edit/Audit manual list presents the ESC number first and the Edit number second. The ESC number is the one that appears on the Pend screen and the number you need to access when you look up a resolution. The Edit number is the one that prints on the RA.
4. Use the keyboard down arrow key to scroll down and find the ESC number you are looking for, and then click on the desired code to highlight the selection or enter the ESC and/or partial description of the ESC and then click on the desired code to highlight the selection. Click on the Display button.
  - a. Alternatively, you could enter the ESC number from the **Pend** screen in the **ESC Number** field on the **HELP** screen and click on *Display*.
5. The requested edit/audit information displays. If the edit pends to a █████ location, the resolution instructions can be accessed by clicking View Resolution as PDF at the end of the display.
6. In cases of multiple ESC numbers for a single Edit number, the detailed resolution instructions are shown only on the first ESC number for the Edit number. All other ESC entries have a comment directing you to the ESC that lists the instructions. Use the Back button on the menu bar to return to the previous screen and enter the ESC number to which you were referred to find the resolution instructions. If you wish to print the edit information, click on the Print button at the top of the edit page.
7. Resolve the edit according to the instructions in the Resolution field.

- a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual resolution instructions for each error code, refer to the Edit/Audit Manual, which can be accessed through the online Help website at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>.

### 3.6.2 Resolving Paper Claim Keying Errors Identified with a media code of 3 or 4

DMAS restrictions prohibit entry of certain fields on the pend resolution screens. Such fields are protected, meaning that when entry is attempted, a message displays and the entry is not allowed. Some fields are absent altogether from the pend resolution screens. If a keying error is detected in a protected field, Resolution staff denies the claim and reprocess it through the claims processing system.

#### Procedure:

1. Review the payment request image and compare the data to the data on the Pend screen. Pay particular attention to the fields that are part of the edit criteria. For instance, if the error is a possible duplicate, look for keying errors in the Member, Provider, Procedure, and Date of Service fields.
2. If a keying error is noted and the field containing the incorrect data is unprotected, that is updateable, key the correct data as shown on the image over the incorrect data in the field on the Pend screen. Release pends to adjudication.
3. If a keying error is noted and the field containing the incorrect data is protected, that is not updateable, deny pend with ESC number 0098 and enter a D in the Disposition Indicator field.
4. Print the payment request image and place in a holding area to be picked up and routed to Data Prep for re-imaging.

### 3.6.3 Transferring Pended Payment Request to Supervisor

If you are working pend and encounter a problem you are not able to resolve, you can send pend to your supervisor for assistance. This should only be done as a last resort after you have tried all means available to resolve pends.

If you do transfer to your supervisor, you must enter comments that explain exactly why you have sent the claim to the Supervisor. Your supervisor monitors this function closely.

#### Procedure:

1. If you determine you need to refer pend to your supervisor, enter the location code 250 in the Location To field that follows the Location From field.
2. Click on the Comment button at the bottom of the screen. The Comment screen displays.
3. Enter comments stating specifically why you are referring pend to the Supervisor.
4. Refer to Section 3.7.5 - Enter Online Pend Resolution Comments for further instructions on entering remarks.

#### Supervisor

5. Accesses pend Location 250 daily to review and resolve claims pending to this location.
6. Enter comments as needed to explain resolution.

### 3.6.4 Transferring Pending Payment Request to DMAS

Resolution instructions for some edits indicate that pending should be routed to DMAS. The instructions should indicate the specific DMAS location code.

Whenever you route pending to DMAS, you must enter comments that explain exactly why you have referred pending.

**Procedure:**

1. If you are instructed to refer pending to a DMAS location, enter the appropriate location code in the Location To field that follows the Location From field.
2. Click on the Comment button at the bottom of the screen. The Comment screen displays.
3. Enter comments stating specifically why you are referring pending to DMAS.
4. Refer to Section 3.7.5 - Enter Online Pending Resolution Comment for further instructions on entering remarks.

### 3.6.5 Entering Online Pending Resolution Comments

The Online Pending Resolution Comment Entry screen (CP-S-001-10) is used to annotate error resolution during the resolution process. This screen can be accessed from any of the Online Pending Resolution screens as necessary to document the action taken. Comments must be entered whenever a pending payment request is transferred to another location.

**Procedure:**

1. Click on the Comment button at the bottom of the Pending screen. The Online Pending Resolution Comments Entry screen (CP-S-00110) displays.
2. The system populates fields identifying the ICN of the pending claim, the Transfer From and Transfer To locations and the transfer date.
3. Enter freeform text in the comments field indicating the specific reasons you are transferring pending. Be brief and specific (e.g., Review Op report, IC requested).
4. Click Update to post the comments.
  - a. For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system. For resolution instructions for each error code, refer to the Edit/Audit Manual, which can be accessed through the online website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

## (CP-S-001-10)

Screen ID: CP-S-001-10  
Trans ID: VH32  
Program ID: CPA124VA

VIRGINIA MEDICAID  
ONLINE PEND RESOLUTION  
COMMENTS ENTRY

Date: 12/29/2009  
Time: 09:27  
Page: 01 of 01

ICN: 2009231300236901

Entry Date	Entry Time	Location From	Location To	User ID	Comments
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	
12/29/2009	09:27	100	100	XA025__	

Update Clear Form Refresh Return Sub Menu Main Menu

### 3.6.6 Entering Consent Forms

Consent forms must be submitted with payment requests for abortion, hysterectomy, and sterilization procedures. The system applies the following rules:

With the implementation of HIPAA, providers are allowed to submit payment requests electronically for the above-cited procedures and submit the required attachment separately on paper. The electronic claim and the paper attachment both include an Attachment Control Number (shown on the Pend screen as Atch #) Click on the Attach button, which allows retrieval of the attachment image when working the pended claim.

#### Procedure:

1. Claims for these procedures are checked against the Consent File to verify that a English or Spanish consent form has been posted for the procedure and dates of service.
  - a. If consent is found on file and all information matches the claim, the claim is paid.
  - b. If consent is not on file and there is no attachment and no ACN, the claim is denied.
  - c. If consent is not on file and there is an attachment, the claim is pended. Pend codes are:
    - 1) 278 Review of Sterilization Consent Form
    - 2) 810 Review of Abortion Consent Form
    - 3) 811 Review of Hysterectomy Consent Form

2. If a claim pends and the consent form is attached, the Pend Resolution Tech enters information from the form onto the Online Pend Resolution Consent Entry screen. (CP-S-001-11)
3. If a claim pends for consent form required, access the attachment image:
  - a. For a paper claim, scroll down on the image retrieval screen to the attachment that follows the claim image.
  - b. For an electronic or Direct Data Entry claim, look for the Atch# on the Pend screen. Click on the Attachment button for to access the attachment image. See Section 3.6.7 for further instructions on retrieving attachments for electronic claims.
4. Review the consent form and the service and verify that the consent form meets all requirements.
  - a. If the form has errors (patient did not sign form, dates are outside time requirements), deny the claim using the appropriate ESC code for the edit (see edit instructions). In addition to the ESC code, enter the appropriate EOB that explains the specific reason the consent form is not valid. The list of EOB codes and messages is on the following page.
  - b. If the form has no errors, click on the Consent button on the Pend screen and enter the consent form information on the screen.
  - c. Click "Update" button to update keyed data
  - d. Return to pend and click the Adjudication button to release the claim to adjudicate. The claim should pay based on consent form information unless other errors set.
    - 1) For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system. For resolution instructions for each error code, refer to the Edit/Audit Manual, which can be accessed through the online Help website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.



### 3.6.8 Pended Payment Request Location 650

Some edits automatically generate a letter to the provider requesting additional information, such as ER report or a DMAS form. These edits park pends for 24 days in Pend Location 650 awaiting receipt of the requested information. The provider is instructed to return the information with a copy of the letter in order to match the information to the original pending claim using the ICN that is printed on the letter. When the letter and requested information are received in Data Prep, the documents are to be worked daily because the pending claim is automatically denied or paid at a reduced rate if not worked within the number of recycle days set for the edit.

Service Level Agreement): Process Suspended Claims in ≤ 30 days from original pend date

#### Procedure:

1. Receive the letter with attached documentation or CD from Data Prep. Date stamp the letter with the date of receipt.
  - a. If multiple letters are attached, Date stamp and key only the top letter. Reps are not required to look thru a set of documents to determine if more than one letter is within a set of documents.
2. Access the pended claim from the Claims Processing Main Menu (CP-S-001-01) by selecting the **Pend Resolution Menu. (You must have security authorization to access pended claims in location 650)**
3. From the ER letter, enter the ICN of the pended claim in the ICN block and click **ENTER** to display the pended claim
4. When the pended claim is displayed, check the **Claim Type and Error fields** to determine which location the claim should be transferred to or if the claim should be worked as a pended claim.
  - a. Claim Type 05 letters should be transferred to location 314
  - b. Claim Type 05 with an **Error:** of 290 should be transferred to location 313
  - c. Claim Type 05 with an Error: of 286 should be worked as a pended claim following the Online Procedures for edit 286 in the Edit Audit Manual and the documentation should be shredded.
  - d. Claim Type 03 letters should be transferred to location 312
  - e. Claim Type 03 with an **Error:** of 290 should be transferred to location 313
  - f. Claim Type 01 letters should be transferred to location 333
5. Enter the appropriate DMAS location code in the **Loc To** field on the Resolution screen and click **Enter**.
6. When the **Comments** screen appears, key in a comment to indicate that the documentation has been received and is being forwarded to DMAS.
  - a. Example: Documentation Received
7. Click **Update**
8. When the message remarks **Entry Successful** appears in red towards the bottom left corner of the screen, click **Return** then **Enter** to get back to the Online Pend Menu (CP-S-001-02) to transfer the next pended claim.

9. MMIS Error Messages:
  - a. **Claim Pended to Auto Recycle Location 600** is displayed when a claim has been flagged for auto adjudication or already paid and the process for that transaction is complete.
    - 1) **ICN Not In Pend Status** is displayed when a claim has already paid or purged off of the system
    - 2) Verify that the ICN was keyed correctly
    - 3) If not, rekey the correct ICN
    - 4) Check the wording on the letter
      - a) **If noted as CLIENT Medical Management Program**
        - i. **With a claim attached**, return letter and claim to the mailroom for processing
        - ii. **Without a claim attached**, return letter and documentation to the provider using the Return to Provider Letter
        - iii. On the Return to Provider Letter, check the box to indicate **Documentation Not Received Timely**. See Appendices 5
      - b) **If not noted as CLIENT Medical Management Program**
        - i. **With a claim attached**, return to the mailroom for processing
        - ii. **Without a claim attached**, shred letter and documentation
10. If multiple letters are attached to one set of documentation, only key the top letter
11. As you are keying the letters, all letters must be separated by **Claim Type and/or Error Messages** and should be forwarded to the following DMAS staff based on the following:
  - a) **DMAS Payment Processing Supervisor:**
    - i. Claim Type 03 letters transferred to location 312
    - ii. Claim Type 05 letters transferred to location 314
  - b) **Deanna Harvey:**
    - i. Claim Type 05 letters transferred to location 313
    - ii. Claim Type 03 letters transferred to location 313
  - c) **Alyson Desalvo:**
    - a. **Claim Type 01 letters transferred to location 333**
12. Each separated stack requires a header sheet identifying the person at DMAS to receive the letter, the mailing date and the number letters in the stack. See appendix 10.
13. Box letters according to the person you are sending them to.
14. Carry boxes to the mailroom for courier pickup to DMAS.

Notes:

1. To verify the status of a letter in the event you don't remember if it was transferred or transferred correctly, follow the following steps:
  1. Select **CHIRP**
  2. Key in the ICN
  3. Select Inquiry and Both
  4. Key in the ICN of the letter in question
  5. Click Enter
  6. Click Status
  7. Highlight the Begin Date and click off of it
  8. Click Detail
  9. Stroll down to the second page to see if a User ID and Comments are noted. If noted, the letter has been transferred. If not, the letter has to be transferred.
  
2. If a letter is received with no attachments, return the letter to the provider using the Return to Provider Letter indicating in the **Other** block that no attachments were received.

## 3.7 Payment Request Adjustment and Void

Adjusting/voiding individual payment requests is an online function that can only be done by a Claims Supervisor or a Complex Claims Specialist.

Claims are adjusted or voided when an █████ Fiscal Agent Services pended claim requires a conflicting claim be adjusted or voided. █████ Fiscal Agent Services only adjusts or voids claims due to the improper processing on behalf of █████ Fiscal Agent Services.

### 3.7.1 Adjusting Individual Payment Request

A Claims Supervisor or Complex Claims Specialist can adjust individual payment requests online using VA MMIS.

**Procedure:**

1. From the main VA MMIS Main Menu screen, click the Claims button to display the Adjustment Selection screen.
2. Select the Adjustment radio button in the Select Function box.
3. Select the Adjust option from the Request Type drop down menu which indicates that the claim is being adjusted.
4. Enter the adjustment reason code.

5. Enter the ICN of the claim to be adjusted.
6. Click the Enter button.
7. You see the CHIRP (Adjust/Void) detail screen for the ICN you entered.
8. Enter the data needed to adjust the claim.
9. Click the Enter button to submit the data entered.
10. When all data entered passes the edits, make a screen print.
11. Click the Accept button to adjudicate the claim or choose Cancel if you do not want to process the request.
12. If the adjusted claim pends, go to the Pend screen to work the pended claim, using the ICN from the printed screen print.
13. Click the Sub Menu button to leave the program.

### 3.7.2 Voiding Individual Payment Request

A Claims Supervisor or Complex Claims Specialist can void individual payment requests online using VAMMIS.

#### Procedure:

1. From the VA MMIS Main Menu screen, click the the Claims Subsystem button to display the Adjustment Selection screen..
2. Select the Adjustment radio button in the Select Function box
3. Select the Void option from the Request Type drop down box.which indicates that the claim is being voided.
4. Enter the void reason code.
5. Enter the ICN of the claim to be voided.
6. Click on the Enter button.
7. You see the CHIRP (Adjust/Void) detail screen for the ICN you entered.
8. Look over the claim to make sure it is the claim you want to void
9. Click the Enter button to verify the results of the void process.Click the *Accept* button to void the claim - or – Click the *Cancel* button to cancel the action.
10. Click the Sub Menu button to leave the program.

## 3.8 Managing Pend Resolution Procedures

### 3.8.1 Evaluating Resolution Procedures Changes

Error resolution procedures must be approved by DMAS prior to any implementation of a process. Changes may be initiated either by DMAS or by VMAP operations. DMAS submits requests for change to the VAMMIS Manager, who then discusses the process to be developed and the impact on operations with the Operations Manager to evaluate any new or existing procedures for efficiency and productivity. These procedures are submitted to DMAS for approval. DMAS works with the Operations Manager and the Resolution Supervisor to define and clarify the intent and execution of the change. DMAS

notifies the Operations Manager, in writing, of the approval of the change, which is then incorporated into the Edit/Audit Manual.

**Procedure:**

1. Receive request from DMAS to add, change or delete resolution procedures for a specific edit. This may take the form of e-mail, memo, or DMAS letter.
2. The Operations Manager and the Pend Resolution Supervisor review the instructions and determine how the instructions impact the procedures established for the edit in question.
3. If clarification is needed, the Pend Resolution Supervisor discusses the instruction with the DMAS reviewer.
4. The Pend Resolution Supervisor drafts a procedure that addresses the DMAS instructions and submits the draft to DMAS for approval. This may be done through e-mail or submitted to the DMAS reviewer in person.
5. DMAS approves the procedure.

### 3.8.2 Documenting Resolution Procedure Changes

When DMAS approves changes/additions to edit resolution procedures, the VAMMIS documentaries incorporates them into the Edit/Audit Manual. If the change also affects the procedures in the Claims Resolution Procedures Manual, the Resolution Supervisor initiates these changes. The Resolution Supervisor drafts the changes in a Word document and submits the Word document to the Document Management team to be incorporated into the Claims Resolution Operations Procedures Manual.

**Procedure:**

1. Receive approval from DMAS for the edit resolution change.
2. Determine whether a change is also needed to the Claims Resolution Operations Procedures Manual. If so, write the change in a Word document.
3. Submit soft copies of the changes to the edit resolution, to the VAMMIS documentaries who updates the edit resolution.
4. Submit soft and hard copies of the changes to the Claims Resolution Operations Procedures Manual to the Document Management team for update of the manual.
5. After changes have been entered, review the results to verify accuracy. If corrections are needed, submit corrections to the Documentaries and/or the Document Management team as appropriate.
6. Once the changes are documented, notify staff of the changes and conduct training, if needed.

# 4 Pend Location Assignment Table Maintenance Procedures

The Claims Resolutions screens are accessed by location code. Each operator is assigned to one or more location codes and can only work pends for the location(s) to which they are assigned. The Claims Processing Subsystem provides a screen that allows add and changes to the table that maintains user pend locations. The Resolution Supervisor has security to access and update this table through the online User Pend Location Screen (CP-S-001-00).

## 4.1 Adding, Changing, or Deleting and Inquiring

### Procedure:

1. On the Main System Menu, click on the Claims button. The Claims Processing Main Menu displays.
2. Click on User Pend Locations radio button to display the User Pend Location Screen.
3. Click the Change (for add, Update and Delete) or Inquiry radio button to select the Function.
4. Enter the User ID (alpha character and four (4) numerals) of the person whose access you want to add, change, delete or inquire and then click the Enter button.
5. If the User ID you entered is not on file, the message No Records Found displays. You may then enter the record.
  - a. Enter A in the Select field.
  - b. Enter the User ID in the User ID field.
  - c. Enter the three-digit Location Code (100, 200, and 250) in the Location field.
  - d. If the user is to be limited to a specific provider's claims, enter the Provider ID in the Provider field. If no restriction, enter all zeros. Choose Enter to edit the entry.
  - e. When the entry is free of errors, choose Update to post the record.
  - f. You may then enter another location for the same user or go on to the next user. The Clear Form button clears the screen to allow a new start.
6. To change or delete an existing user record, Step 4 results in display of a list of all locations assigned to the user.
  - a. To add a new location, follow the same steps used in Step 5.

- b. To delete a location, enter a D in the Select field beside the record to be deleted. Choose Update to delete the record.
- c. To Change a record, enter a C in the Select field beside the record to be changed. Enter the change in the appropriate field. Choose Enter to edit the entry. Choose Update to post the record.
  - 1) For more details on specific screen navigation and field entries or specific data elements, refer to the online Claims Processing Subsystem User Manual and/or the online Help system. A sample screen is displayed below.

# 5 Appendices and Supporting Documents

# 5.1 Return to Provider Letter Sample



Commonwealth of Virginia  
Department of Medical Assistance Services

Dear Provider:

The attached claim(s) is/are being returned for the following reason(s):

- \_\_\_ MISSING OR INVALID RENDERING AND/OR BILLING PROVIDER NUMBER(S)
- \_\_\_ MISSING, INVALID PROVIDER QUALIFIER OR QUALIFIER USED IN WRONG LOCATOR(S)  
(Review blocks 17a, 17b, 24I, 24J, 33a or 33b. See billing instructions)
- \_\_\_ ATTACHMENT(S) MUST BE 8 ½ x 11 inches
- \_\_\_ DAMAGED IN PROCESSING. PLEASE RESUBMIT
- \_\_\_ TITLE 18: ADJUSTMENT/VOID –CHECK THE APPROPRIATE BLOCK
- \_\_\_ DO NOT ENTER LEGACY PROVIDER NUMBER IF BILLING WITH NPI. LEAVE LOCATORS 17a, 24I, 24J and 33b SHADED AREAS BLANK. DO NOT ENTER QUALIFIER(S).
- \_\_\_ QUALIFIER ENTERED WITH NO PROVIDER NUMBER.
- \_\_\_ ENTER THE LEGACY PROVIDER NUMBER IN THE SHADED AREA IN BLOCK 24J WITH THE QUALIFIER 1D IN 24I. ADD QUALIFIER AND LEGACY PROVIDER NUMBER IN 33b.
- \_\_\_ AUTHORIZED SIGNATURE/DATE MISSING
- \_\_\_ BILLING INFORMATION NOT CONFINED TO AVAILABLE SPACE/DATA NOT ALIGNED
- \_\_\_ TOO MANY CLAIM LINES/ TOO MANY PAGES/MISSING PAGES
- \_\_\_ ILLEGIBLE OR MISSING CHARGE
- \_\_\_ INVALID PRIMARY CARRIER AMOUNT
- \_\_\_ INSUFFICIENT INFORMATION FOR PROCESSING (Each block must be Completed properly. See billing instructions)
- \_\_\_ CLAIM SUBMITTED ON AN OBSOLETE FORM OR FORM VERSION IS NOT ACCEPTED AT THIS TIME
- \_\_\_ NOT A VALID VA MEDICAID CLAIM FORM
- \_\_\_ SUBMIT TO DMAS CONTRACTOR (DENTAL, PA, etc)
- \_\_\_ DOCUMENTATION NOT RECEIVED TIMELY.  
PAYMENT REDUCED (Please resubmit as an adjustment with documentation)
- \_\_\_ INVALID REVENUE CODE (4 digit code 0XXX)
- \_\_\_ ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY
- \_\_\_ PRINT IS TOO LIGHT or SMALL FOR IMAGING OR SCANNING (recommend Sans Serif 10)
- \_\_\_ CARBON COPIES ARE NOT SUITABLE FOR IMAGING OR SCANNING
- \_\_\_ MARGINS NOT ALIGNED PROPERLY - DOES NOT MATCH ORIGINAL CLAIM FORM  
(Downloaded forms from the DMAS website should be printed at 100%, actual size and no page scaling)
- \_\_\_ ILLEGIBLE INFORMATION
- \_\_\_ PA REQUESTS NEED TO BE SUBMITTED TO THE APPROPRIATE ORGANIZATION. SEE PROVIDER MANUALS/MEMOS
- \_\_\_ SHADED AREA FOR TPL OR NDC INFORMATION ONLY. USE QUALIFIERS 'TPL' OR 'N4'
- \_\_\_ COB (Coordination of Benefits) CODES 2, 3, 5 ARE NO LONGER VALID. SEE PROVIDER MANUAL/MEMOS FOR TPL BILLING
- \_\_\_ COMMENT(S) AND OR LABEL(S) INTERFERES WITH THE PROCESSING OF CLAIM (Please remove and resubmit)

OTHER \_\_\_\_\_

Please return the corrected claims for processing.  
Fiscal Agent, Xerox State Healthcare, LLC Rev 10/2013

\_\_\_\_\_  
Tech                      Date (mm/dd/yy)

## 5.2 Provider Enrollment Application - Data Entry



### COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

#### Physician

#### VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

Thank you for your interest in becoming a participating provider with the Virginia Medicaid program. Upon receipt of your completed Virginia Medicaid / Family Access to Medical Insurance Security Plan (FAMIS) enrollment application and any required documents, your application will be processed. Processing of your application may take up to ten business days. Completed paper enrollment applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free Fax 1-888-335-8476

Virginia Medicaid Provider Enrollment Services  
PO Box 26803  
Richmond, VA 23261-6803

If you have any questions regarding your paper enrollment application, you can contact Provider Enrollment Services toll-free at 1-888-829-5373 or local 1-804-270-5105.

#### Contents:

- Enrollment Form Instructions - Read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Make sure all required fields are complete prior to submission.
- Reassignment of Benefits (ROB) Form - Make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.

**VIRGINIA MEDICAID ENROLLMENT FORM**

**SECTION I: PROVIDER DEMOGRAPHIC INFORMATION**

1. **National Provider Identifier (NPI) (Required)** \_\_\_\_\_

2. **Individual Provider Name (Required)**  
First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_ Title \_\_\_\_\_  
*Enter the name which identifies individual provider to the public*

3. **Primary Servicing Address (Required)**  
If you are a member of a group practice, enter the group practice NPI for this servicing address \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone (Required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (Required) \_\_\_\_\_  
Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

4. **Correspondence Address (Required)**  
Attention \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (Required) \_\_\_\_\_  
Do you want to receive mailed Medicaid correspondence at this address?  Yes or  No

5. **Pay To Address (Optional)**  
Attention \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_  
Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

6. **Remittance Advice Address (Optional)**  
Attention \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_

7. **Social Security Number (SSN) and Date of Birth (Required)**  
SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

8. **IRS Name and Taxpayer Identification Number (Optional for individuals who bill and accept payments through a group practice)**  
IRS Name \_\_\_\_\_  
Taxpayer Identification Number (TIN) \_\_\_\_\_

9. **Doing Business as (DBA) Name (Optional)** \_\_\_\_\_

10. **Requested Effective Date of Enrollment (Required)** \_\_\_\_\_

11. **License and Required Documents (Required)**

**State Medical Board** State \_\_\_\_\_

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

Attach Copy if your license cannot be validated through an Internet search.

**DPOR** State \_\_\_\_\_

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

Attach Copy if your license cannot be validated through an Internet search.

12. **Specific Requirements for Different Provider Types (Required)**

12.1. **Specific Requirements for Baby Care Services (Required)**

Select all services that you are applying for.

**Care Coordination (Attach Copy)**

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

**Homemaker Services (Attach Copy)**

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

**Nutritional Services (Attach Copy)**

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

**Patient Education Services (Attach Request for Approval and Supporting Documents)**

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

12.2. **Specific Requirements for Chiropractors (Required)**

Attach copy of claim(s) for services rendered or supporting documentation indicating services to be rendered

12.3. **Specific Requirements for Nurse Practitioner (Required)**

Select one specialty

Acute Care

Adult

Certified Nurse Midwife

Family

Geriatric

Neonatal

Pediatric

Psychiatric

Women's Health (OB/GYN.)

12.4. **Specific Requirements for Psychiatrists (Required)**

Attach copy of Provider's Three Year Residence Certification of Curriculum Vitae or Three Year Residency in Psychiatry.

13. **Mammography Services (Required)**

Are you currently conducting breast cancer screening or diagnosis through mammography activities?  Yes  No

If Yes, attach a copy of the required certification issued by the FDA under the Mammography Quality Standards Act (MQSA).

**14. Medical Specialties (Primary Specialty Required)**

**14.1. Primary Specialty (Required) select one**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesiology           | <input type="checkbox"/> Infectious Disease      | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Cardiac Surgery          | <input type="checkbox"/> Internal Medicine       | <input type="checkbox"/> Plastic Surgery                    |
| <input type="checkbox"/> Cardiology               | <input type="checkbox"/> Neonatology             | <input type="checkbox"/> Preventative Medicine              |
| <input type="checkbox"/> Colon and Rectal Surgery | <input type="checkbox"/> Nephrology              | <input type="checkbox"/> Psychiatry                         |
| <input type="checkbox"/> Critical Care            | <input type="checkbox"/> Neurological Surgery    | <input type="checkbox"/> Pulmonary                          |
| <input type="checkbox"/> Dermatology              | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Radiation Oncology                 |
| <input type="checkbox"/> Doctor of Osteopathy     | <input type="checkbox"/> Nuclear Medicine        | <input type="checkbox"/> Radiology                          |
| <input type="checkbox"/> Emergency                | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Rheumatoid                         |
| <input type="checkbox"/> Endocrinology            | <input type="checkbox"/> Ophthalmology           | <input type="checkbox"/> Substance Abuse                    |
| <input type="checkbox"/> Ear, Nose, and Throat    | <input type="checkbox"/> Orthopedic Surgery      | <input type="checkbox"/> Surgery Cardiothoracic             |
| <input type="checkbox"/> Family Practice          | <input type="checkbox"/> Osteopathy              | <input type="checkbox"/> Thoracic Surgery                   |
| <input type="checkbox"/> Gastroenterology         | <input type="checkbox"/> Otolaryngology          | <input type="checkbox"/> Transplant Surgery                 |
| <input type="checkbox"/> General Practice         | <input type="checkbox"/> Pathologist             | <input type="checkbox"/> Urology                            |
| <input type="checkbox"/> General Surgery          | <input type="checkbox"/> Pediatrics              | <input type="checkbox"/> Vascular                           |
| <input type="checkbox"/> Hematology/Oncology      | <input type="checkbox"/> Perinatology            |   |

**14.2. Secondary Specialties (Optional) select all that apply**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesiology           | <input type="checkbox"/> Infectious Disease      | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Cardiac Surgery          | <input type="checkbox"/> Internal Medicine       | <input type="checkbox"/> Plastic Surgery                    |
| <input type="checkbox"/> Cardiology               | <input type="checkbox"/> Neonatology             | <input type="checkbox"/> Preventative Medicine              |
| <input type="checkbox"/> Colon and Rectal Surgery | <input type="checkbox"/> Nephrology              | <input type="checkbox"/> Psychiatry                         |
| <input type="checkbox"/> Critical Care            | <input type="checkbox"/> Neurological Surgery    | <input type="checkbox"/> Pulmonary                          |
| <input type="checkbox"/> Dermatology              | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Radiation Oncology                 |
| <input type="checkbox"/> Doctor of Osteopathy     | <input type="checkbox"/> Nuclear Medicine        | <input type="checkbox"/> Radiology                          |
| <input type="checkbox"/> Emergency                | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Rheumatoid                         |
| <input type="checkbox"/> Endocrinology            | <input type="checkbox"/> Ophthalmology           | <input type="checkbox"/> Substance Abuse                    |
| <input type="checkbox"/> Ear, Nose, and Throat    | <input type="checkbox"/> Orthopedic Surgery      | <input type="checkbox"/> Surgery Cardiothoracic             |
| <input type="checkbox"/> Family Practice          | <input type="checkbox"/> Osteopathy              | <input type="checkbox"/> Thoracic Surgery                   |
| <input type="checkbox"/> Gastroenterology         | <input type="checkbox"/> Otolaryngology          | <input type="checkbox"/> Transplant Surgery                 |
| <input type="checkbox"/> General Practice         | <input type="checkbox"/> Pathologist             | <input type="checkbox"/> Urology                            |
| <input type="checkbox"/> General Surgery          | <input type="checkbox"/> Pediatrics              | <input type="checkbox"/> Vascular                           |
| <input type="checkbox"/> Hematology/Oncology      | <input type="checkbox"/> Perinatology            |   |

**15. Languages Other Than English Spoken - Check All That Apply (Optional)**

- Farsi  Hindi  Korean  Spanish  Vietnamese  Other: \_\_\_\_\_

**16. Signature Waiver  Yes  No (Required)**

I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.

**SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104. AND 42 C.F.R. §455.106.**

**17. Ownership and Control Information for Disclosing Entity (Required)**

List any managing employee and/or any individual(s) or organization(s) that has any ownership or controlling interest in this provider entity. The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement.

List the Individual Name or Organization Name, Title (i.e. CEO, MD, Pres.), Date of Birth, SSN/Tax ID (TIN), Type of Ownership, Address and Percentage of Ownership. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**18. Relationships (Required)**

List those individuals named in the previous question who are related to each other (spouse, parent, child, or sibling) and whom they are related to.

Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		
Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		
Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		
Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**19. Subcontractors (Required)**

List the Name, Title, Date of Birth, SSN/TIN, Address and Percentage of Ownership for any individual with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**20. Other Disclosing Entity (Required)**

List the name, title, Date of Birth, SSN/TIN, Percent Ownership and Address of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more.

Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN		Percent		
Street Address	City	State	Zip		

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**21. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)**

Has any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

No  Yes (if Yes please provide the Name, Title, Date of Birth, Address, and SSN/TIN information for individual(s) or organization(s). Attach copy of the final disposition.

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If more space is needed, attach additional paper listing all of the required information for the additional individual or organization.

**22. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)**

Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

No  Yes (if yes, please provide the Name, Date of Birth, Address, and SSN/TIN information for the individual(s) or contractors below. Attach a copy of the final disposition.

Name/Organization \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If more space is needed attach additional paper listing all of the required information for the additional individual or organization.

**23. Adverse Legal Actions (Required)**

Indicate if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, any other Federal or State agency or program, or any licensing or certification agency.

No  Yes If Yes, attach a copy of any final disposition documentation.

**SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION (Required)**

**24. Electronic Funds Transfer (Required for Solo Practitioners. Optional for Individuals Who Bill and Accept Payments through a Group Practice)**

Yes, I will participate in EFT of payments directly deposited into my financial account. Complete the following:

Account Type     Checking     Savings     Other

Name of Financial Institution \_\_\_\_\_

Routing or ABA number \_\_\_\_\_

Account Number \_\_\_\_\_

No, I am filing for an exemption from participation in EFT for good cause.

I am attaching a letter from my financial institution stating the inability of the institution to transact business using EFT.

I am attaching a letter describing my good cause for exemption.

**25. Electronic Claims Submission (Required for Solo Practitioners. Optional for Individuals Who Practice with a Group)**

I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE) on the Virginia Medicaid Web Portal as part of my enrollment with Virginia Medicaid and FAMIS.

I am requesting an exemption from filing my claim(s) electronically at this time for the following reasons:

Unavailability of the infrastructure necessary to support electronic claims submission in my geographic region. If checked attach supporting documentation.

No mechanism for electronic submission for the particular claim types I bill Virginia Medicaid. If checked attach supporting documentation.

Financial Hardship. If checked, attach supporting documentation.

Other: \_\_\_\_\_  
To be considered for an exemption, attach supporting documentation.

**26. Electronic Remittance Advice (ERA) (Optional)**

Yes, I would like to request participation in electronic remittance advices as part of my enrollment with Virginia Medicaid and FAMIS. Complete the following:

Service Center Name \_\_\_\_\_

Service Center ID Number \_\_\_\_\_

**SECTION IV: REASSIGNMENT OF BENEFITS (ROB)**

The completion of this section is required for individuals who bill and accept payments through a group practice. Make additional copies of the ROB as necessary for enrollment into additional Group Practice NPIs under same TIN.

**27. Reassignment of Benefits (ROB) (Optional)**

Group Practice Legal Business Name \_\_\_\_\_

Group Practice Taxpayer Identification Number (TIN) \_\_\_\_\_

Group Practice National Provider Identifier (NPI) \_\_\_\_\_

Yes I certify that the authorized administrator listed for this group has validated the information above for this group that it is true, accurate, and complete to the best of the applying provider's knowledge, and that the business entity (employer, group, or health care delivery system) requesting to receive payment is legally eligible to receive reassigned benefits per all applicable federal and state laws.

Group Authorized Administrator \_\_\_\_\_

Yes I certify that this Reassignment of Benefits Statement authorizes the business entity identified in above to receive Virginia Medicaid payments on my behalf.

Individual Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**28. Remarks (Optional)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**COMMONWEALTH of VIRGINIA**  
**Department of Medical Assistance Services**  
**Medical Assistance Program**  
Physician Participation Agreement

**This is to certify:**

**Provider Name** \_\_\_\_\_

**NPI** \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC. 794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
11. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. This agreement shall commence upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. The provider shall retain a copy of this approval letter as part of the Participation Agreement. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

**For Virginia Medicaid use only**

Director, Division of Program Operations	Date
--	------

\_\_\_\_\_  
Original Signature of Provider      Date

**Addendum A - Additional Servicing Addresses (make additional copies as needed)**

A. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone (required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

B. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone (required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

C. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

D. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone (required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_



# 5.4 Uniform Assessment Instrument (UAI) Form Sample

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT		
		Date: Person _____
		Assessment: _____
		Reassessment: _____
<b>1 IDENTIFICATION/BACKGROUND</b>		
<b>Name &amp; Vital Information</b>		
Client Name: _____	(Last) (First) (Middle Initial)	Client SSN: _____
Address: _____	(Street) (City) (State) (Zip Code)	
Phone: ( ) _____	City/County Code: _____	
Directions to Home: _____		Pets? _____
<b>Demographics</b>		
Birthdate: _____	Age: _____	Sex: _____ Male <input type="checkbox"/> Female <input type="checkbox"/>
(Month) (Day) (Year)		
Marital Status: _____	Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/>	
Married <input type="checkbox"/>		
Race: _____	Education: _____	Communication of Needs: _____
White <input type="checkbox"/>	Less than High School <input type="checkbox"/>	Verbally, English <input type="checkbox"/>
Black/African American <input type="checkbox"/>	Some High School <input type="checkbox"/>	Verbally, Other Language <input type="checkbox"/>
American Indian <input type="checkbox"/>	High School Graduate <input type="checkbox"/>	Specify _____
Other/Hispanic <input type="checkbox"/>	Some College <input type="checkbox"/>	Sign Language/Gestures/Deaf <input type="checkbox"/>
Alaskan Native <input type="checkbox"/>	College Graduate <input type="checkbox"/>	Does Not Communicate <input type="checkbox"/>
Unknown <input type="checkbox"/>	Unknown <input type="checkbox"/>	Hearing Impaired? _____
Ethnic Origin: _____	Specify _____	
<b>Primary Caregiver/Emergency Contact/Primary Physician</b>		
Name: _____	Relationship: _____	
Address: _____	Phone: ( ) _____ ( ) _____	
Name: _____	Relationship: _____	
Address: _____	Phone: ( ) _____ ( ) _____	
Name of Primary Physician: _____	Phone: _____	
Address: _____		
<b>Initial Contact</b>		
Who called: _____	(Name) (Relationship to Client) (Phone)	
Presenting Problem/Diagnosis: _____		

UAI Part A 1

# 5.5 Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions (DMAS-95) Form Sample

## SCREENING FOR MENTAL ILLNESS, MENTAL RETARDATION/INTELLECTUAL DISABILITY, OR RELATED CONDITIONS

A. This section is to be completed by the Pre-admission Screening Committee. **This form applies to NF Admissions ONLY.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date PAS Request Received \_\_\_\_\_

Social Security No. \_\_\_\_\_ Medicaid No. \_\_\_\_\_ Responsible CSB \_\_\_\_\_

1. DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?

Yes  No (If NO - see DMAS-95 MI/MR/ID/RC Instructions.)

a. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs?  Yes  No

**If "Yes", this form must be completed AND the DMAS-95 form authorization is for Nursing Facility, this form MUST BE COMPLETED.**

2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?  Yes  No

(Check "Yes" only if answers a, b, and c below are "Yes". If "No", do not refer for assessment of active treatment needs for MI Diagnosis.)

a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder, somatoform disorder, personality disorder, other psychotic disorder, or other mental disorder that may lead to a chronic disability)?

Yes  No

b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning, concentration, persistence, or pace, and adaptation to change?  Yes  No

c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder?  Yes  No

3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR)/INTELLECTUAL DISABILITY (ID) WHICH WAS MANIFESTED BEFORE AGE 18?

Yes  No

4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION?  Yes  No

(Check "Yes" only if each item below is Checked "Yes". If "No", do not refer for assessment of active treatment needs for related condition.)

a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR/ID because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR/ID persons and requires treatment of services similar to those for these persons?  Yes  No

b. Has the condition manifested before age 22?  Yes  No

c. Is the condition likely to continue indefinitely?  Yes  No

d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living?  Yes (If yes, circle applicable areas)  No

5. RECOMMENDATION (Either "a" or "b" must be checked.)

a.  Refer for secondary assessment. (NF Placement = Level II refer to DDM Ascend) (Waiver Placement = 101B refer to Local CSB)

MI (# 2 above is checked "Yes")

MR or Related Condition (# 3 or # 4 is checked "Yes")

Dual diagnosis (MI and MR/ID or Related Condition categories are checked)

**\*\* NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded LTC until the secondary assessment has been completed.**

b.  No referral for active treatment needs assessment required because individual:

Does not meet the applicable criteria for serious MI or MR/ID or related condition

Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR/ID

Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI

Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stem level, or other conditions which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services.)

Is terminally ill (note: a physician must have documented that individual's life expectancy is six (6) months or less)

Signature & Title: \_\_\_\_\_ Screening Committee: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Street Address: \_\_\_\_\_

DMAS-95 MI/MR/ID/RC (revised 12/08)





# 5.8 CMS 1500 Form Sample



## HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
CITY STATE		8. RESERVED FOR NUCC USE	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		b. OTHER CLAIM ID (Designated by NUCC)	
15. OTHER DATE MM DD YY QUAL		c. INSURANCE PLAN NAME OR PROGRAM NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a and 9d.	
17a. _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17b. NPI _____		SIGNED _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
A. _____ B. _____ C. _____ D. _____		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
E. _____ F. _____ G. _____ H. _____		22. RESUBMISSION CODE ORIGINAL REF. NO. _____	
I. _____ J. _____ K. _____ L. _____		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. (FPS) Fee Per Unit 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 prior claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	
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.)		29. AMOUNT PAID \$	
SIGNED _____ DATE _____		30. Rsvd for NUCC use	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH. # ( )	
a. NPI _____ b. _____		a. NPI _____ b. _____	

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

WCMS-1500CS-12

# 5.9 Direct Data Entry CMS 1500 Form Sample

## CMS1500 Health Insurance Claim Form

(Submitted through the Web Portal)

### Submission Information

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Submitter: v [REDACTED]

ICN: [REDACTED]

### Patient and Insured Information

1. Medicaid 1a. Insured's ID Number: [REDACTED]

TDO/ECO Indicator:

#### 2. Patient's Name

Last Name: [REDACTED]

First Name: [REDACTED] MI:

3a. Patient's DOB: [REDACTED] 3b. Gender: F-FEMALE

#### 4. Insured's Name:

Last Name:

First Name: MI:

#### 5. Patient's Address:

Address: [REDACTED]

Address 2:

City: [REDACTED] State: [REDACTED]

Zip & Extension: [REDACTED]

6. Patient's Relationship to Insured: SELF

#### 7. Insured's Address:

Address: [REDACTED]

Address 2:

City: [REDACTED] State: [REDACTED]

Zip & Extension: [REDACTED]

8. Patient Marital Status: Employment:

#### 9. Other Insured's Name:

Last Name: [REDACTED]

First Name: [REDACTED] MI:

a. Other Insured's Group or Policy #:

b1. Other Insured's DOB: b2. Gender:

c. Employer's Name or School Name:

d. Insurance Plan Name or Program Name: MEDICARE

#### 10. Is Patient's Condition Related To:

a. Employment? NO

b. Auto Accident? NO State:

c. Other Accident: NO

d. Reserved for Local Use:

Does the Claim have Attachments: YES

Attachment Control Number (ACN): [REDACTED]

Patient Account Number: [REDACTED] Date Of Service: [REDACTED]

Sequence Number: 4

11. Insured's Policy Group or FECA Number:  
a1. Insured's DOB: a2. Gender:  
b. Employer's Name or School Name:  
c. Insurance Plan Name or Program Name:  
d. Is There Another Health Benefit Plan: YES
12. Patient's or Authorized Person's Signature: SIGNATURE ON FILE Date:  
04/10/2014
13. Insured's or Authorized Person's Signature: SIGNATURE ON FILE Date:  
04/10/2014
- Physician or Supplier Information**
14. Date of Current:  
15. If Patient has had Same/Similar Illness, First Date:  
16. Dates Patient unable to work in current occupation:  
From: To :
17. Name of Referring Provider or Other Source:  
Name of Referring Provider: [REDACTED]
- a. ID Qualifier: Medicaid Provider ID:  
b. Referring Provider NPI: [REDACTED]
18. Hospitalization Dates Related to Current Services:  
From: To:
19. Reserved for Local Use:  
20. Outside Lab? NO Charges: 0.00
21. Diagnosis or Nature of Illness or Injury:  
A. 7514  
B. 2349  
C. 0389  
D. 27651  
E.  
F.  
G.  
H.  
I.  
J.  
K.  
L.
22. Is this a void/replacement of a paid claim: NO  
a. Medicaid Resubmission Code:  
b. ICN to Credit/Adjust:
23. Prior Authorization Number:  
24.1 ICN: [REDACTED]
- A. Date(s) of Service: From: 04/01/2013 To : 04/01/2013  
B. Place of Service: 12-HOME  
C. Emergency Indicator: NO  
D. Procedures, Services or Supplies:  
Procedure Code: B9004  
Modifier: 1. RR  
2. 22  
3.  
4.
- E. Diagnosis Code:  
Pointers: 1. A  
2.  
3.  
4.

**F. Submitted Charges:** 449.08  
**G. Days or Units:** 1  
**H1. EPSDT Indicator:** NO **H2. Family Planning Indicator:** NO  
**I. ID Qualifier:**

**J1. Rendering Provider ID:** **J2. Rendering Provider NPI:** [REDACTED]

**Supplemental Data (Line 24 - Shaded Area):** TPL0.00

**24.2 ICN:** [REDACTED]

**A. Date(s) of Service: From:** 04/01/2013 **To :** 04/01/2013

**B. Place of Service:** 12-HOME

**C. Emergency Indicator:** NO

**D. Procedures, Services or Supplies:**

**Procedure Code:** E0776

**Modifier:** 1. RR

2. 22

3.

4.

**E. Diagnosis Code:**

**Pointers:** 1. A

2.

3.

4.

**F. Submitted Charges:** 26.00

**G. Days or Units:** 1

**H1. EPSDT Indicator:** NO **H2. Family Planning Indicator:** NO

**I. ID Qualifier:**

**J1. Rendering Provider ID:** **J2. Rendering Provider NPI:** [REDACTED]

**Supplemental Data (Line 24 - Shaded Area):** TPL0.00

**24.3 ICN:** [REDACTED]

**A. Date(s) of Service: From:** 04/06/2013 **To :** 04/09/2013

**B. Place of Service:** 12-HOME

**C. Emergency Indicator:** NO

**D. Procedures, Services or Supplies:**

**Procedure Code:** B4197

**Modifier:** 1. 22

2.

3.

4.

**E. Diagnosis Code:**

**Pointers:** 1. A

2.

3.

4.

**F. Submitted Charges:** 943.20

**G. Days or Units:** 3

**H1. EPSDT Indicator:** NO **H2. Family Planning Indicator:** NO

**I. ID Qualifier:**

**J1. Rendering Provider ID:** **J2. Rendering Provider NPI:** [REDACTED]

**Supplemental Data (Line 24 - Shaded Area):** TPL0.00

**24.4 ICN:** [REDACTED]

**A. Date(s) of Service: From:** 04/06/2013 **To :** 04/09/2013

**B. Place of Service:** 12-HOME

**C. Emergency Indicator:** NO

**D. Procedures, Services or Supplies:**

**Procedure Code:** B4220

**Modifier: 1. 22**

2.

3.

4.

**E. Diagnosis Code:**

**Pointers: 1. A**

2.

3.

4.

**F. Submitted Charges: 27.00**

**G. Days or Units: 3**

**H1. EPSDT Indicator: NO H2. Family Planning Indicator: NO**

**I. ID Qualifier:**

**J1. Rendering Provider ID: J2. Rendering Provider NPI: [REDACTED]**

**Supplemental Data (Line 24 - Shaded Area): TPL0.00**

**24.5 ICN: [REDACTED]**

**A. Date(s) of Service: From: 04/06/2013 To : 04/09/2013**

**B. Place of Service: 12-HOME**

**C. Emergency Indicator: NO**

**D. Procedures, Services or Supplies:**

**Procedure Code: B4224**

**Modifier: 1. 22**

2.

3.

4.

**E. Diagnosis Code:**

**Pointers: 1. A**

2.

3.

4.

**F. Submitted Charges: 84.33**

**G. Days or Units: 3**

**H1. EPSDT Indicator: NO H2. Family Planning Indicator: NO**

**I. ID Qualifier:**

**J1. Rendering Provider ID: J2. Rendering Provider NPI: [REDACTED]**

**Supplemental Data (Line 24 - Shaded Area): TPL0.00**

**24.6 ICN: [REDACTED]**

**A. Date(s) of Service: From: 04/06/2013 To : 04/09/2013**

**B. Place of Service: 12-HOME**

**C. Emergency Indicator: NO**

**D. Procedures, Services or Supplies:**

**Procedure Code: B4185**

**Modifier: 1. 22**

2.

3.

4.

**E. Diagnosis Code:**

**Pointers: 1. A**

2.

3.

4.

**F. Submitted Charges: 171.50**

**G. Days or Units: 14**

**H1. EPSDT Indicator: NO H2. Family Planning Indicator: NO**

**I. ID Qualifier:**

**J1. Rendering Provider ID: J2. Rendering Provider NPI:** [REDACTED]

**Supplemental Data (Line 24 - Shaded Area):** TPL0.00

**25. Federal Tax I.D. Number:** [REDACTED] **SSN/FEIN:** FEIN

**26. Patient's Account No:** [REDACTED] **27. Accept Assignment?:** YES

**28. Total Charge:** 1701.11

**29. Amount Paid:** 0.00

**30. Balance Due:** 1701.11

**31. Signature of Physician or Supplier:** **Web Date:** 04/10/2014

**32. Name and Address of Facility Where Services Were Rendered:**

Org/Last Name:

First Name: MI:

Address:

Address 2:

City: State:

Zip & Extension:

NPI:

ID Qualifier: Medicaid Provider ID/Taxonomy:

**33. Physician's, Supplier's Billing Name, Address and Zip Code:**

Org/Last Name: [REDACTED]

First Name: MI:

Address: [REDACTED]

Address 2:

City: [REDACTED] State: [REDACTED]

Zip & Extension: [REDACTED]

NPI: [REDACTED]

ID Qualifier: Medicaid Provider ID/Taxonomy:

# 5.10 UB04 Form Sample

1		2		36 PAY CONT. #		4		4	
				37 NEW REC. #					
				38 FED. TAX NO.		39 STATEMENT COVER PERIOD FROM		39 STATEMENT COVER PERIOD THROUGH	
8 PATIENT NAME				9 PATIENT ADDRESS					
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 DR. 14 TYPE 15 SRC		16 DMF	
17 STAT		18		19		20		21	
22		23		24		25		26	
27		28		29		30		31	
32		33		34		35		36	
37		38		39		40		41	
42		43		44		45		46	
47		48		49		50		51	
52		53		54		55		56	
57		58		59		60		61	
62		63		64		65		66	
67		68		69		70		71	
72		73		74		75		76	
77		78		79		80		81	
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92		93		94		95		96	
97		98		99		100		101	
102		103		104		105		106	
107		108		109		110		111	
112		113		114		115		116	
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122		123		124		125		126	
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132		133		134		135		136	
137		138		139		140		141	
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227		228		229		230		231	
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242		243		244		245		246	
247		248		249		250		251	
252		253		254		255		256	
257		258		259		260		261	
262		263		264		265		266	
267		268		269		270		271	
272		273		274		275		276	
277		278		279		280		281	
282		283		284		285		286	
287		288		289		290		291	
292		293		294		295		296	
297		298		299		300		301	
302		303		304		305		306	
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312		313		314		315		316	
317		318		319		320		321	
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412		413		414		415		416	
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467		468		469		470		471	
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507		508		509		510		511	
512		513		514		515		516	
517		518		519		520		521	
522		523		524		525		526	
527		528		529		530		531	
532		533		534		535		536	
537		538		539		540		541	
542		543		544		545		546	
547		548		549		550		551	
552		553		554		555		556	
557		558		559		560		561	
562		563		564		565		566	
567		568		569		570		571	
572		573		574		575		576	
577		578		579		580		581	
582		583		584		585		586	
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597		598		599		600		601	
602		603		604		605		606	
607		608		609		610		611	
612		613		614		615		616	
617		618		619		620		621	
622		623		624		625		626	
627		628		629		630		631	
632		633		634		635		636	
637		638		639		640		641	
642		643		644		645		646	
647		648		649		650		651	
652		653		654		655		656	
657		658		659		660		661	
662		663		664		665		666	
667		668		669		670		671	
672		673		674		675		676	
677		678		679		680		681	
682		683		684		685		686	
687		688		689		690		691	
692		693		694		695		696	
697		698		699		700		701	
702		703		704		705		706	
707		708		709		710		711	
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722		723		724		725		726	
727		728		729		730		731	
732		733		734		735		736	
737		738		739		740		741	
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752		753		754		755		756	
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762		763		764		765		766	
767		768		769		770		771	
772		773		774		775		776	
777		778		779		780		781	
782		783		784		785		786	
787		788		789		790		791	
792		793		794		795		796	
797		798		799		800		801	
802		803		804		805		806	
807		808		809		810		811	
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837		838		839		840		841	
842		843		844		845		846	
847		848		849		850		851	
852		853		854		855		856	
857		858		859		860		861	
862		863		864		865		866	
867		868		869		870		871	
872		873		874		875		876	
877		878		879		880		881	
882		883		884		885		886	
887		888		889		890		891	
892		893		894		895		896	
897		898		899		900		901	
902		903		904		905		906	
907		908		909		910		911	
912		913		914		915		916	
917									

# 5.11 Direct Data Entry UB04 Form Sample

UB04 Insurance Claim Form  
(Submitted through the Web Portal)

## Submission Information

Submitter:  
ICN:

## Institutional Claim Information

### 1. Billing Provider Information

Org/Last Name:  
First Name: MI: Suffix:  
Address:  
Address2:  
City: State: VA  
Zip & Extension: Country Code: USA  
Telephone: Fax:

### 2. Pay-To Provider Information

Org/Last Name:  
First Name: MI: Suffix:  
Address:  
Address2:  
City: State:  
Zip & Extension:

### 3a. Patient Control Number:

b. Medical Record Number:

### 4. Type of Bill:

### 5. Federal Tax No:

### 6. Statement Covers Period:

From: Through:

### 7. NUBC Use: N/A

### 8a. Patient's ID:

### b. Patient's Name

Last Name:  
First Name: MI: Suffix:

### 9. Patient's Address:

a. Address:  
b. City: c. State:  
d. Zip & Extension: e. Country Code: USA

### 10. Patient's Birthdate:

### 11. Sex:

### 12. Admission Date:

### 13. Admission Hour:

### 14. Priority Type of Visit:

### 15. Referral for Admission Source:

### 16. Discharge Hour:

### 17. Patient Discharge Status:

### 18. Condition Codes:

### 19. Condition Codes:

### 20. Condition Codes:

### 21. Condition Codes:



- 43. Revenue Description:
- 44. HCPCS/Rates/HIPPS Rate Codes:
- 45. Service Dates:
- 46. Service Units:
- 47. Total Charges:
- 48. Non Covered Charges:
- 49. NUBC Use: N/A
- Total Submitted Charges:
- 50.A Payer Name:
- 51. Health Plan ID:
- 52. Release Info Code:
- 53. Assignment of Benefits Certification Indicator:
- 54. Prior Payments:
- 55. Estimated Claim Amount Due:
- 56. NPI:
- 57. Other Provider Identifier:
- 58. Insured's Name:
- Last Name:
- First Name: MI:
- 59. Patient's Relationship to Insured:
- 60. Insured Unique ID:
- 61. Group Name:
- 62. Insurance Group Number:
- 63. Treatment Authorization Code:
- 64. ICN to Credit/Adjust:
- 65. Employer Name:
- 50.B Payer Name:
- 51. Health Plan ID:
- 52. Release Info Code:
- 53. Assignment of Benefits Certification Indicator:
- 54. Prior Payments:
- 55. Estimated Claim Amount Due:
- 57. Other Provider Identifier:
- 58. Insured's Name:
- Last Name:
- First Name: MI:
- 59. Patient's Relationship to Insured:
- 60. Insured Unique ID:
- 61. Group Name:
- 62. Insurance Group Number:
- 63. Treatment Authorization Code:
- 64. ICN to Credit/Adjust:
- 65. Employer Name:
- 66. Diagnosis and Procedure Code Qualifier:
- 67. Principal Diagnosis Code: POA Code:
- a. Other Diagnosis Code: POA Code:
- b. Other Diagnosis Code: POA Code:
- c. Other Diagnosis Code: POA Code:
- d. Other Diagnosis Code: POA Code:
- e. Other Diagnosis Code: POA Code:
- f. Other Diagnosis Code: POA Code:

g. Other Diagnosis Code: POA Code:  
 h. Other Diagnosis Code: POA Code:  
 i. Other Diagnosis Code: POA Code:  
 j. Other Diagnosis Code: POA Code:  
 k. Other Diagnosis Code: POA Code:  
 l. Other Diagnosis Code: POA Code:  
 m. Other Diagnosis Code: POA Code:  
 n. Other Diagnosis Code: POA Code:  
 o. Other Diagnosis Code: POA Code:  
 p. Other Diagnosis Code: POA Code:  
 q. Other Diagnosis Code: POA Code:  
 68. Resubmission Type Code:  
 69. Admitting Diagnosis:  
 70. Patient Reason DX:  
 a.  
 b.  
 c.  
 71. Prospective Payment System Code:  
 72. External Cause of Injury:  
 a. POA Code:  
 b. POA Code:  
 c. POA Code:  
 73. NUBC Use: N/A  
 74. Principal Procedure  
 Code: Date:  
 74a. Other Procedure  
 Code: Date:  
 74b. Other Procedure  
 Code: Date:  
 74c. Other Procedure  
 Code: Date:  
 74d. Other Procedure  
 Code: Date:  
 74e. Other Procedure  
 Code: Date:  
 75. NUBC Use: N/A  
 76. Attending Provider Name and Identifiers  
 Attending NPI: ID Qualifier: Attending Physician ID:  
 Last Name:  
 First Name: MI: Suffix:  
 77. Operating Physician Name and Identifiers  
 Operating NPI: ID Qualifier: Operating Physician ID:  
 Last Name:  
 First Name: MI: Suffix:  
 78. Other 1  
 Other NPI: ID Qualifier: Other Physician ID:  
 Last Name:  
 First Name: MI: Suffix:  
 79. Other 2  
 Other NPI: ID Qualifier: Other Physician ID:  
 Last Name:  
 First Name: MI: Suffix:  
 80. Remarks:  
 Does the Claim have Attachments:  
 Attachment Control Number (ACN):



# 5.13 Dental 2002 Form Sample

## ADA Dental Claim Form

HEADER INFORMATION																										
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services - OR - <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																										
2. Predetermination/Preauthorization Number																										
PRIMARY PAYER INFORMATION					PRIMARY SUBSCRIBER INFORMATION																					
3. Name, Address, City, State, Zip Code					12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																					
					13. Date of Birth (MM/DD/CCYY)		14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Subscriber Identifier (SSN or ID#)																	
OTHER COVERAGE																										
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																										
5. Subscriber Name (Last, First, Middle Initial, Suffix)																										
PATIENT INFORMATION																										
6. Date of Birth (MM/DD/CCYY)					7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Subscriber Identifier (SSN or ID#)		19. Student Status <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> FTS <input type="checkbox"/> PTS																	
9. Plan/Group Number					10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																					
11. Other Carrier Name, Address, City, State, Zip Code					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																					
					21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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										32. Other Fee(s)
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										33. Total Fee
35. Remarks																										
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION																
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.										38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other										39. Number of Enclosures (00 to 99) Radiographs Oral Images Models						
X _____ Patient/Guardian signature Date										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					41. Date Appliance Placed (MM/DD/CCYY)											
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										42. Months of Treatment Remaining					43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					44. Date Prior Placement (MM/DD/CCYY)						
X _____ Subscriber signature Date										45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																
48. Name, Address, City, State, Zip Code										46. Date of Accident (MM/DD/CCYY)										47. Auto Accident State						
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION																
49. Provider ID										50. License Number					51. SSN or TIN					52. Phone Number ( ) -						
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



# 5.15 Pharmacy Claim Form Sample

PLEASE PRINT CLEARLY

Virginia Department of Medical Assistance  
Services PHARMACY CLAIM FORM



01 Provider Medicaid ID Number	02 Patient's Last Name	03 Patient's First Name	04 Patient's Medicaid ID Number	05 Sex	06 Birth Date MM	07 DO	08 OOH
09 Local ID#	10 Disp. Date	11 Unit	12 NDC Number	13 Product	14 Brand Name	15 Original Reference Number	16 Prescription Number
17 Date Dispensed MM	18 DO	19 OOH	20 NDC Number	21 MFRS. QTY. Disp. Quantity	22 Unit Cost	23 PAUSE	24 Payment by Primary Center
25 Provider Authorization Number	26 Provider's Medicaid ID Number	27 Diagnosis	28 Amount Billed	29 COC	30 Payment by Primary Center	31 Partial Fill Information	32 Date of
33 Unit	34 Day Intended to be Dispensed	35 Intended Days Supply	36 Amount Billed	37 Assessed Day Dispensed MM	38 DO	39 OOH	40
41 Local ID#	42 Disp. Date	43 Unit	44 NDC Number	45 Product	46 Brand Name	47 Original Reference Number	48 Prescription Number
49 Date Dispensed MM	50 DO	51 OOH	52 NDC Number	53 MFRS. QTY. Disp. Quantity	54 Unit Cost	55 PAUSE	56 Payment by Primary Center
57 Provider Authorization Number	58 Provider's Medicaid ID Number	59 Diagnosis	60 Amount Billed	61 COC	62 Payment by Primary Center	63 Partial Fill Information	64 Date of
65 Unit	66 Day Intended to be Dispensed	67 Intended Days Supply	68 Amount Billed	69 Assessed Day Dispensed MM	70 DO	71 OOH	72
73 Local ID#	74 Disp. Date	75 Unit	76 NDC Number	77 Product	78 Brand Name	79 Original Reference Number	80 Prescription Number
81 Date Dispensed MM	82 DO	83 OOH	84 NDC Number	85 MFRS. QTY. Disp. Quantity	86 Unit Cost	87 PAUSE	88 Payment by Primary Center
89 Provider Authorization Number	90 Provider's Medicaid ID Number	91 Diagnosis	92 Amount Billed	93 COC	94 Payment by Primary Center	95 Partial Fill Information	96 Date of
97 Unit	98 Day Intended to be Dispensed	99 Intended Days Supply	100 Amount Billed	101 Assessed Day Dispensed MM	102 DO	103 OOH	104
105 Local ID#	106 Disp. Date	107 Unit	108 NDC Number	109 Product	110 Brand Name	111 Original Reference Number	112 Prescription Number
113 Date Dispensed MM	114 DO	115 OOH	116 NDC Number	117 MFRS. QTY. Disp. Quantity	118 Unit Cost	119 PAUSE	120 Payment by Primary Center
121 Provider Authorization Number	122 Provider's Medicaid ID Number	123 Diagnosis	124 Amount Billed	125 COC	126 Payment by Primary Center	127 Partial Fill Information	128 Date of
129 Unit	130 Day Intended to be Dispensed	131 Intended Days Supply	132 Amount Billed	133 Assessed Day Dispensed MM	134 DO	135 OOH	136
137 Local ID#	138 Disp. Date	139 Unit	140 NDC Number	141 Product	142 Brand Name	143 Original Reference Number	144 Prescription Number
145 Date Dispensed MM	146 DO	147 OOH	148 NDC Number	149 MFRS. QTY. Disp. Quantity	150 Unit Cost	151 PAUSE	152 Payment by Primary Center
153 Provider Authorization Number	154 Provider's Medicaid ID Number	155 Diagnosis	156 Amount Billed	157 COC	158 Payment by Primary Center	159 Partial Fill Information	160 Date of
161 Unit	162 Day Intended to be Dispensed	163 Intended Days Supply	164 Amount Billed	165 Assessed Day Dispensed MM	166 DO	167 OOH	168
169 Comments:							
170 Provider Name, Address and Telephone Number	<p>This is to certify that the foregoing information is true, accurate and complete. I understand that payment and reimbursement of this claim will be held in abeyance until the State Department of Health Services is satisfied that any applicable federal, state or local laws or regulations are being followed. Payment may be withheld until the applicable federal or state laws.</p> <p>Signature of Provider or Representative</p> <p>39</p>						
DMAAS-173-R-6/03	Date (mm/dd-yy) <input type="text"/>						

# 5.16 Compound Pharmacy Claim Form Sample

Virginia Department of Medical Assistance Services  
**COMPOUND PRESCRIPTION  
 PHARMACY CLAIM FORM**



01 Remittance Code		02 Original Reference Number	
03 <input type="text"/>		<input type="text"/>	
04	05	06	07
Provider's Medicaid ID Number	Level of Service	Diagnosis	BAMC
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
08 <input type="text"/>		09 <input type="text"/>	
Prior Authorization Number		Patient's Date of Birth	
09 <input type="text"/>		<input type="text"/>	
10 <input type="text"/>		11 <input type="text"/>	
Medicaid ID Number		Last Name	
<input type="text"/>		<input type="text"/>	
12 <input type="text"/>		13 <input type="text"/>	
Prescriber's Medicaid ID Number		Prescription Number	
<input type="text"/>		<input type="text"/>	
14 <input type="text"/>		15 <input type="text"/>	
Date Dispensed		Days Supply	
<input type="text"/>		<input type="text"/>	
16 <input type="text"/>		17 <input type="text"/>	
Refill		Retail Location	
<input type="text"/>		<input type="text"/>	
18 <input type="text"/>		19 <input type="text"/>	
HCPCS Number		20 DAW	
<input type="text"/>		<input type="text"/>	
21 Description/Drug Name		22 Metric Decimal Quantity	
<input type="text"/>		<input type="text"/>	
1		-	
<input type="text"/>		<input type="text"/>	
2		-	
<input type="text"/>		<input type="text"/>	
3		-	
<input type="text"/>		<input type="text"/>	
4		-	
<input type="text"/>		<input type="text"/>	
5		-	
<input type="text"/>		<input type="text"/>	
6		-	
<input type="text"/>		<input type="text"/>	
7		-	
<input type="text"/>		<input type="text"/>	
8		-	
<input type="text"/>		<input type="text"/>	
9		-	
<input type="text"/>		<input type="text"/>	
10		-	
<input type="text"/>		<input type="text"/>	
11		-	
<input type="text"/>		<input type="text"/>	
12		-	
<input type="text"/>		<input type="text"/>	
13		-	
<input type="text"/>		<input type="text"/>	
23 Other Coverage Code		24 Amount Paid by Primary Payer	
<input type="text"/>		<input type="text"/>	
25 Amount Billed (include dispensing fee)		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
26 Comments:			
<hr/>			
<hr/>			
<hr/>			
27 Provider Name, Address and Telephone Number		<small>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.</small>	
<input type="text"/>		Signature of Provider or Representative & Date	
<input type="text"/>		Date	
<input type="text"/>		<input type="text"/>	
DMAS-174 R 6/03		28 <input type="text"/>	

# 5.17 Electronic Attachment Form Sample

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

\*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:
------------------	----------------

Enrollee Identification Number:
---------------------------------

Enrollee Last Name:	First Name:	MI:
---------------------	-------------	-----

<input type="checkbox"/> Paper Attached	<input type="checkbox"/> Photo(s) Attached	<input type="checkbox"/> X-Ray(s) Attached
<input type="checkbox"/> Other (specify) _____		

COMMENTS: _____ _____ _____ _____ _____
---

THIS IS TO CERTIFY THAT THE FORGOING 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

Authorized Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Mailing addresses are available in the Provider manuals or check DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov) Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3R 603

## 5.18 Direct Data Entry Claim Submittal Attachment Form

Claim Submitted - DMAS2013/09

Your Professional claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

**Claim Information**

ICN Numbers: [REDACTED]      ACM: [REDACTED]

Date of Service: [REDACTED]  
Provider #: [REDACTED]  
Provider Name: [REDACTED]  
Member ID: [REDACTED]  
Member Name: [REDACTED]  
Total Charge: [REDACTED]  
Submission Date/Time: [REDACTED]

**Mailing Address**

Please send additional documentation to the following address:

**Department of Medical Assistance Services**  
Practitioner  
9000w 21444  
Richmond, Virginia 23251-7444

[Print Submission Page](#)    [Submit Another Claim](#)    [Claims Menu](#)

Claim Submitted

Your Institutional claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

**Claim Information**

ICN: [REDACTED]      ACM: [REDACTED]

Date of Service: [REDACTED]  
Provider #: [REDACTED]  
Provider Name: [REDACTED]  
Member ID: [REDACTED]  
Member Name: [REDACTED]  
Total Charge: [REDACTED]  
Submission Date/Time: [REDACTED]

**Mailing Address**

Please send additional documentation to the following address:

**Department of Medical Assistance Services**  
Practitioner  
9000w 21444  
Richmond, Virginia 23261-7444

[Print Submission Page](#)    [Submit Another Claim](#)    [Claims Menu](#)



## 5.19.1 Sterilization Consent Form - Spanish

Virginia Department of Medical Assistance Services

### CONSENTIMIENTO PARA LA ESTERILIZACIÓN

**NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.**

#### ■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información de \_\_\_\_\_ (nombre del médico)

sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizado/a es completamente mía. Me dijeron que yo podría decidir no ser esterilizado/a. Si decidí no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cualquier otro beneficio en el futuro. No perderé ninguna asistencia o beneficio de programa patrocinado con fondos federales, tales como el programa de asistencia temporal para familias necesitadas (TANF) o Medicaid, que recibo actualmente o para los cuales seré elegible.

ENTiendo QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de planificación disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizado/a.

Entiendo que seré esterilizado/a por medio de una operación conocida como \_\_\_\_\_ (nombre de la operación). Me han explicado los riesgos, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firmo esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizado/a no resultará en la reducción de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací en \_\_\_\_\_ (país, estado, etc.)

Yo, \_\_\_\_\_ (nombre de la persona esterilizada), por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizado/a por \_\_\_\_\_ (nombre del médico) por \_\_\_\_\_ (nombre de la operación).

Basado en \_\_\_\_\_ (nombre de la operación), mi consentimiento vence 180 días a partir de la fecha en la que firmo este documento.

También doy mi consentimiento para que se presente esta Forma y otros expedientes médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

\_\_\_\_\_ (Nombre) \_\_\_\_\_ (Fecha) \_\_\_\_\_ (país, estado, etc.)

Se le ruega proporcionar la siguiente información, aunque no es obligatorio hacerlo:

Definición de raza y origen étnico (mencione uno)

Indio Americano / Nativo de Alaska

Asiático

Negro (No de origen hispano)

Filipino o hawaiano

Blanco (No de origen hispano)

#### ■ DECLARACIÓN DEL INTÉRPRETE ■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He interpretado la información y los consejos que verbalmente se le han presentado a la persona que será esterilizado/a por el individuo que ha obtenido este consentimiento. También le he leído a sí/ella la Forma de consentimiento en idioma \_\_\_\_\_ y le he explicado el contenido de esta forma.

A mi mejor saber y entender, sí/ella ha entendido esta explicación.

\_\_\_\_\_ (Nombre del intérprete) \_\_\_\_\_ (Fecha) \_\_\_\_\_ (país, estado, etc.)

#### ■ DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO ■

Antes de que \_\_\_\_\_ (nombre de la persona)

firmara la Forma de Consentimiento para la Esterilización, le he explicado a sí/ella los detalles de la operación \_\_\_\_\_ (nombre de la operación) para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y los riesgos, los riesgos y los beneficios asociados con esta procedimiento.

He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de planificación que son temporales. Le he explicado que la esterilización es definitiva porque es permanente.

Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que sí/ella no perderá ningún servicio o salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Sí/ella ha solicitado con conocimiento de causa y por libre voluntad ser esterilizado/a y parece entender la naturaleza del procedimiento y sus consecuencias.

\_\_\_\_\_ (Nombre de la persona que obtiene el consentimiento) \_\_\_\_\_ (Fecha)

\_\_\_\_\_ (Nombre)

#### ■ DECLARACIÓN DEL MÉDICO ■

Previo a realizar la operación para la esterilización a \_\_\_\_\_ (nombre de la persona esterilizada)

en \_\_\_\_\_ (nombre de la operación) \_\_\_\_\_ (nombre de la operación) \_\_\_\_\_ (nombre de la operación)

operación para la esterilización \_\_\_\_\_ (nombre de la operación)

del hecho de que es un procedimiento con un resultado final e irreversible, y los riesgos, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que será esterilizada que hay disponibles otros métodos de planificación que son temporales. Le expliqué que la esterilización es definitiva porque es permanente.

Le informé a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que sí/ella no perderá ningún servicio o salud o ningún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Sí/ella ha solicitado con conocimiento de causa y libre voluntad ser esterilizado/a y parece entender el procedimiento y las consecuencias de este procedimiento.

(Instrucciones para uso o alternativa de párrafos finales: Utilice el primer párrafo que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización en menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el segundo párrafo que se presenta a continuación. Tache con una X el párrafo que no se aplique.)

(1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (mencione la causa apropiada y escriba la información requerida):

Parto prematuro

Fecha revisada de parto

Cirugía abdominal de emergencia (Escriba las circunstancias): \_\_\_\_\_

\_\_\_\_\_ (Nombre del médico) \_\_\_\_\_ (Fecha)

Deberá complete todos los espacios en blanco. No se aceptan firmas por medio de un sello. Una copia de esta forma deberá ser entregada al paciente. Anexar una copia de esta forma en cada factura

DATA HEALTH SERVICES