Appendix M-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2210, Medical Equipment/Supplies Invoice

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the department:

- Use original department issued claim form. The department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use black or dark blue ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border, as a result of photocopying with the copier cover open, cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. A sample of the HFS 2210 may be found on the department's website.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of provider services.

Completion	Item	Item Explanation and Instructions
Required	**1.**	**Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** - Enter the National Provider Identifier (NPI) number.
Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**4.**	**Billing Date** – Enter the date the claim form was prepared. Use MMDDYY format.
Optional	**5.**	**Provider Reference** – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on the HFS 194-M-2, Remittance Advice, returned to the provider.
Optional	**6.**	**Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the department will not attempt corrections.

Completion	Item	Item Explanation and Instructions
Optional	**7.**	**Provider City, State, ZIP** - Enter city, state and ZIP code of provider address. See Item 6 above.
Revised Effective October 2018	**8.**	**Service Sections** – The form provides five service sections to list the specific items for which reimbursement is being requested. These service sections can be used to bill up to five items for the same patient. Claims with an attachment may only identify one date of service. At least one service section must be completed, as follows:
Required		**Recipient Name (First, MI, Last)** - Enter the patient's name. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required		**Recipient No.** - Enter the nine digit number assigned to the individual. Do not use punctuation or spaces. Do not use the Case Identification Number.
Optional		**Birth date** - Enter the month, day and year of birth of the patient. Use the MMDDYY format.
Conditionally Required		**Accident/Injury** - When applicable, enter one of the following codes to indicate the nature of any accident or injury that necessitated the patient's need for the medical equipment or supplies: 1 - A work-related accident or illness 2 - A motor vehicle accident 3 - Participation in an organized sport or school activity 4 - An act of violence (non-accidental) 5 - An unspecified accident
Not Required		Healthy Kids – Leave Blank

Completion	Item	Item Explanation and Instructions
Not Required		Cr. Child – Leave Blank
Conditionally Required		**Delete** - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.
Required		**Diagnosis Description** - Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient's need for the items.
Conditionally Required		**Prefix** - When the ICD-9-CM diagnosis code has an alphabetic prefix of E or V, enter it here. **Do not use this field for the ICD-10-CM diagnosis code set.**
Required		**Diag. Code** - Enter the primary diagnosis code exactly as it appears in the ICD-9-CM, or upon implementation, ICD-10-CM manual. **For ICD-10-CM diagnosis codes, this field will contain both the alpha and numeric characters of the diagnosis code.** Do not enter the decimal point.
Required		**Ordering Practitioner Name (First, Last)** - Enter the name of the practitioner who determined the need for the item dispensed.
Required		**Ordering Practitioner Number** - Enter the ordering practitioner's NPI.
Not Required		Order Number - Leave blank.
Conditionally Required		**Prior Approval** - If the item requires prior approval, enter the last eight digits of the Prior Approval Number from Form HFS 3076A, Prior Approval Notification Letter.
Required		**Cat. Serv.** - Enter the appropriate two-digit category of service (COS) code: 41 Medical Equipment or Prosthetic Devices 48 Medical Supplies The COS code for each item is identified in the DME Fee Schedule on the department's website.

Completion	Item	Item Explanation and Instructions
Required		**Item** - Enter the appropriate five-digit HCPCS code for the item dispensed.
Required		**Purchase/Rent** - Enter one purchase/rental code as follows: For COS 41, Medical Equipment/Prosthetic Devices 1 = Purchase 2 = Rental 3 = Repair 4 = Modification 5 = Loaner For COS 48, Medical Supplies 1 = Purchase Repair charges must be billed with the original procedure code and repair/purchase/rent code or modifier “3”. An itemized breakdown of repair charges must be attached to the claim. For any hand-priced item per the DME Fee Schedule, providers must identify and separate the charges for labor and materials.
Required		**Quantity** - Determine the standard unit for the item, and complete this field based on the amount dispensed, expressed in the standard units defined for this item. The standard unit is generally one (1). Exceptions are identified in the reimbursement listings on the department’s website.
Required		**Date of Service** - Enter the date the service or item was provided to the patient. Use MMDDYY format.
Conditionally Required		**TPL Code** - If payment was received from a third party resource, enter the appropriate three-digit TPL code. Do not enter the lead alpha character. Do not enter the TPL code for Medicare. Enter Code 999 and the name of the payment source in Field 9, “Uncoded TPL Name”, if unknown. If more than one third party made a payment for a particular service or item, list the second company in Field 9, “Uncoded TPL Name” (and include both dollar amounts in the TPL amount).

Completion	Item	Item Explanation and Instructions
		TPL Entries for Spenddown. Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal), the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a recipient liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount The actual recipient liability as shown on the HFS 2432. TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability greater than $0.00 and multiple claims are required to report the charges for all services provided, the claims should be coded as follows: **Claim 1** TPL Code 906 TPL Status 01 TPL Amount The actual recipient liability up to total charges. TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. **Claim 2** TPL Code 906 TPL Status 01 if remaining liability from Claim 1 is greater than $0.00 **or** 04 if remaining recipient liability from Claim 1 is $0.00. TPL Amount If status code 01 was used in Claim 2 status field, enter amount of remaining recipient liability after Claim 1. If status code 04 was used in Claim 2 status field, enter 000. TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Item Explanation and Instructions
		If the HFS 2432 shows a recipient liability of $0.00 and multiple claims are required to report the charges for all services provided, the claims should be coded as follows: **Claim 1** TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. **Claim 2** TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.

Completion	Item	Item Explanation and Instructions
Conditionally Required		**Status** - If a TPL code is shown in the preceding item, a two digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank. The TPL Status Codes are: **01 - TPL Adjudicated - total payment shown**: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 - TPL Adjudicated - patient not covered**: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 - TPL Adjudicated - services not covered**: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that the items or services provided are not covered. **04 - TPL Adjudicated - spenddown met**: TPL status code 04 is to be entered when the patient's Form HFS 2432, Split Billing, shows $0.00 liability. **05 - Patient not covered**: TPL Status Code 05 is to be entered when the patient informs the provider that the third party resource identified is not in force. **06 - Services not covered**: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 - Third Party Adjudication Pending**: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 - Deductible not met**: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Item Explanation and Instructions
Conditionally Required		**TPL Amount** - Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. If there is no TPL code, no entry is required.
Conditionally Required		**TPL Date** - A TPL date is required when any status code is shown in the TPL Status item. Use the date specified below for the applicable code: **Code Date to be entered** 01 - Third Party Adjudication Date 02 - Third Party Adjudication Date 03 - Third Party Adjudication Date 04 - Date from the HFS 2432 05 - Date of Service 06 - Date of Service 07 - Date of Service 10 - Third Party Adjudication Date
Required		**Provider Charge** - Enter the total charge for the Service Section, not deducting any third party liability.
Conditionally Required		**Repeat** - This box appears only in Service Sections 2-5. It may be used when two or more Service Sections are for items supplied to the same patient. When an X is entered in this box, all information in the preceding Service Section will be repeated in the department's claim system, except Date of Service and the TPL fields. If the items dispensed are identical except for Date of Service, the only entries required are an X in the Repeat box and the new Date of Service. If different items are dispensed to the same patient, entries are also required in any fields that differ from the preceding Service Section. The Repeat box may not be used following a Service Section that has been deleted.
Conditionally Required	**9.**	**Uncoded TPL Name** - If TPL code 999 was used in any of the completed Service Sections, the name of the third party health resource must be entered in this field.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**12.**	**Sect. #** - If more than one third party made a payment for a particular service, enter the Service Section number (1-5) in which that service is reported.
Conditionally Required	**13A**	**TPL Code** - Refer to the instructions for **TPL Code** above.
Conditionally Required	**13B**	**Status** - Refer to the instructions for **Status** above.
Conditionally Required	**13C**	**TPL Amount** - Refer to the instructions for **TPL Amount** above.
Conditionally Required	**13D**	**TPL Date** - Refer to the instructions for **TPL Date** above.
Required	**14.**	**# Sects.** - Enter the number of Service Sections completed on this claim. Use a single digit number only. Do not count Service Sections that have been deleted.
Required	**15.**	**Total Charge** - Enter the sum of all charges submitted on this claim in Service Sections 1-5.
Conditionally Required	**16.**	**Total Deductions** - Enter the sum of all payments received from other sources. If no payment was received, leave blank.
Required	**17.**	**Net Charge** - Enter the difference between Total Charge and Total Deductions.
Required		**Provider Certification, Signature and Date** - After reading the certification statement, the provider or authorized designee must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. The signature date is to be entered.

Mailing Instructions

The Medical Equipment/Supplies Invoice is a single page or two-part form. The provider is to submit the original of the form to the department as indicated below. The pin-feed guide strip should be detached from the sides of continuous feed forms. The copy of the claim is to be retained by the provider.

Routine claims are to be mailed to the department in pre-addressed mailing envelopes, Form HFS 2247, Provider Invoice Envelope, provided by the department.

Mailing Address: Illinois Department of Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or HFS 2432 Split Billing Transmittal) are to be mailed to the department in pre-addressed mailing envelope, Form 2248, NIPS Special Handling Envelope, which is provided by the department for this purpose.

Mailing address: Illinois Department of Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Forms Requisition: Billing forms may be requested on our website at the Medical Provider Forms Request page, or by submitting a HFS 1517, as explained in Chapter 100.

Appendix M-2

Technical Guidelines for Paper Claim Preparation
Form HFS 3797 (pdf), Medicare Crossover Invoice

To assure the most efficient processing by the department, please follow these guidelines in the preparation of paper claims for image processing:

- Use original department issued claim form. The department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand-keyed, which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use black or dark blue ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border, as a result of photocopying with the copier cover open, cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797. A sample of Form HFS 3797 Medicare Crossover Invoice may be found on the department's website.

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the HFS 2210 claim form.** Refer to Appendix 1 for billing and mailing information.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the department, and will preclude corrections of certain claim errors by the department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Completion	Item	Item Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the box labeled 26 – Med Equip/Sup/Pharm.
Required	**1.**	**Recipient's Name** - Enter the recipient's name (first, middle, last).
Required	**2.**	**Recipient's Birth date** - Enter the month, day and year of birth. Use the MMDDYY format.
Required	**3.**	**Recipient's Sex** – Enter a capital "X" in the appropriate box.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**4.**	**Was Condition Related to** – **A.** Recipient's Employment - Treatment for an injury or illness that resulted from recipient's employment, enter a capital "X" in the "Yes" box. **B.** Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate. Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.
Required	**5.**	**Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number. Do not use the Case Identification Number.
Required	**6.**	**Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).
Required	**7.**	**Recipient's Relation to Insured** – Enter a capital "X" in the appropriate box.
Required	**8.**	**Recipient's or Authorized Person's Signature** – The recipient, or authorized representative, must sign and enter a date unless the signature is on file with the provider/supplier. **If the signature is on file, enter the statement, "Signature on File," here**.
Conditionally Required	**9.**	**Other Health Insurance Information** - If the recipient has an additional health benefit plan, enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.
Required	**10A**.	**Date(s) of Service** - Enter the date(s) of service submitted to Medicare. Use MMDDYY format in the "From" and "To" fields.
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.
Not Required	10C.	T.O.S. (Type of Service)

Completion	Item	Item Explanation and Instructions
Required	**10D.**	**Days or Units** – Enter the Number of Services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001.
Required	**10E.**	**Procedure Code** - Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
Required	**10F**.	**Amount Allowed** – Enter the amount allowed by Medicare for the item(s) provided as shown on the Explanation of Medicare Benefits (EOMB). If the item was not allowed, bill the item on the HFS 2210 claim form, attach the EOB, and submit it to a billing consultant with a letter requesting an override.
Required	**10G.**	**Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Enter the amount the provider was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	11.	For NDC Use Only
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	13A.	Origin of Service –Leave blank.
Not Required	13B.	Modifier – Leave blank.

Completion	Item	Item Explanation and Instructions
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.
Not Required	15A.	Origin of Service – Leave blank.
Not Required	15B.	Modifier – Leave blank.
Not Required	16A.	Destination of Service – Leave blank.
Not Required	16B.	Modifier – Leave blank.
Optional	**17.**	**ICN #** - Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on Form HFS 194-M-2, Remittance Advice, returned to the provider.
Conditionally Required	**18.**	**Diagnosis or Nature of Injury or Illness** - Enter the description of the diagnosis, or nature of injury or illness, that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-9-CM, or upon implementation, ICD-10-CM code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the valid ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code for the services rendered.
Optional	**18B**.	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code.
Required	**19.**	**Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.
Conditionally Required	**20.**	**Name and Address of Facility Where Services Rendered** This entry is required when Place of Service (10B) is other than provider's office or recipient's home. Enter the facility name and address where the service(s) was furnished. When the name and address of the facility where the services were furnished is the same as the biller's name and address as submitted in Field 22, enter the word, "Same."

Completion	Item	Item Explanation and Instructions
Required	**21.**	**Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to recipients, for the department to consider payment of deductible and coinsurance amounts. Enter a capital “X” in the "Yes" box, if accepting assignment.
Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the physician/supplier name exactly as it appears on the Provider Information Sheet under “Provider Key.”
Required	**23.**	**HFS Provider Number** – Enter the Provider’s NPI.
Required	**24.**	**Payee Code** – Enter the single-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Conditionally Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the referring or ordering practitioner if the service or item was ordered or referred by a practitioner. Referring Practitioner – a practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Practitioner – A practitioner who orders non-physician services for the participant such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a practitioner’s order or referral must include the ordering/referring practitioner’s NPI.
Not Required	27.	Medicare Provider ID Number
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29A.**	**TPL Code** – If payment was received from a third party resource, enter the appropriate TPL code. Do not enter the lead alpha character. Do not enter the TPL code for Medicare. If the TPL code is not known, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Fields 30A – 30D. **TPL Entries for Spenddown**. **TPL Entries for Spenddown**. Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal), the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a recipient liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount The actual recipient liability as shown on the HFS 2432. TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a recipient liability greater than $0.00 and multiple claims are required to report the charges for all services provided, the claims should be coded as follows: **Claim 1** TPL Code 906 TPL Status 01 TPL Amount The actual recipient liability up to total charges. TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. **Claim 2** TPL Code 906 TPL Status 01 if remaining liability from Claim 1 is greater than $0.00 **or** 04 if remaining recipient liability from Claim 1 is $0.00. TPL Amount If status code 01 was used in Claim 2 status field, enter amount of remaining recipient liability after Claim 1. If status code 04 was used in Claim 2 status field, enter 000. TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Item Explanation and Instructions
		If the HFS 2432 shows a recipient liability of $0.00 and multiple claims are required to report the charges for all services provided, the claims should be coded as follows: **Claim 1** TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. **Claim 2** TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29B.**	**TPL Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Item Explanation and Instructions
Conditionally Required	**29C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter $0.00. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.
Conditionally Required	**29D.**	**TPL Date** – A TPL date is required when any status code is shown in Field 29B. Use the date specified below for the applicable TPL status code. Use the MMDDYY format. **Status Code** — **Date to be entered** 01 — Third Party Adjudication Date 02 — Third Party Adjudication Date 03 — Third Party Adjudication Date 04 — Date from the HFS 2432 05 — Date of Service 06 — Date of Service 07 — Date of Service 10 — Third Party Adjudication Date
Conditionally Required	**30A.**	**TPL Code** – (See 29A above).
Conditionally Required	**30B.**	**TPL Status** – (See 29B above).
Conditionally Required	**30C.**	**TPL Amount** – (See 29C above).
Conditionally Required	**30D.**	**TPL Date** – (See 29D above).
Required	**31.**	**Provider Signature** - After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. The provider's signature should not enter the date section of this field.
Required	**32.**	**Date** – The date of the provider's signature is to be entered in the MMDDYY format.

Mailing Instructions

The Medicare Crossover Invoice is a single page or two-part continuous feed form. The provider is to submit the original of the form to the department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the department. The yellow copy of the claim should be retained by the provider.

Invoices are to be mailed to the department in the pre-addressed mailing envelopes, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the department. Should envelopes be unavailable, the HFS 3797 (Medicare Crossover Invoice) can be mailed to:

Medicare Crossover Invoice
Illinois Department of Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Do not bend or fold claims prior to submission.

Forms Requisition: Billing forms may be requested on our website at the Medical Provider Forms Request page, or by submitting a HFS 1517 as explained in Chapter 100.

Appendix M-3

Preparation and Mailing Instructions for Form HFS 1409, Prior Approval Request

Form HFS 1409 Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in the DME Fee Schedule, on the department's website.

Instructions for Completion

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Conditionally Required = Entries that are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable; leave blank.

Completion	Item	Item Explanation and Instructions
Required	**1.**	**Recipient #** – Enter the nine-digit recipient number assigned to the patient for whom the service or item is requested.
Required	**2.**	**Recipient Name –** Enter the name of the patient for whom the service or item is requested.
Required	**3.**	**Birth date** – Enter the patient's birth date.
Required	**4.**	**Provider/NPI # -** The department currently requires that providers report the HFS legacy provider number on the paper prior approval form. Enter the provider number as shown on the Provider Information Sheet.

Completion	Item	Item Explanation and Instructions
Required	**5.**	**Provider Telephone #** - Enter the telephone number of the provider's office. This information is helpful in instances where the department needs additional information in order to act upon the request.
Required	**6.**	**Provider Name –** Enter the name of the supplier who will provide the service or item.
Required	**7.**	**Physician Name –** Enter the name of the practitioner who signed the order or prescription recommending that the patient receive the specific item or service.
Required	**8.**	**Provider Street Address –** Enter the address of the supplier.
Required	**9.**	**Physician Street Address –** Enter the address of the ordering practitioner.
	10.	**Provider City, State, ZIP Code –** Enter the address of the supplier.
Required	**11.**	**Physician City, State, ZIP Code –** Enter the address of the ordering practitioner.
Required	**12.**	**Diagnosis Code –** Enter the ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code that corresponds to the description listed in item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis –** Enter additional ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code, if applicable.
Required	**14.**	**Diagnosis Description –** Enter the written description, which corresponds with the diagnosis code listed in item 12.
Conditionally Required	**15.**	**Patient Height/Weight** – Required for enteral supplements, wheelchairs, and heavy duty equipment.

Completion	Item	Item Explanation and Instructions
Required	**16.**	**Procedure Code –** Enter the five-digit HCPCS code that identifies the specific item/service being requested. **Description –** Briefly describe the services, items or materials to be provided. **Qty –** Enter the number of items/units to be dispensed within the time period covered by the prior approval request. **Cat. Serv –** Enter the two-digit category of service (COS) code corresponding to the related item. Valid entries are: 41 Medical Equipment/Prosthetic Devices 48 Medical Supplies **Prov Charge –** Enter the total amount to be charged for the item(s) being requested. **Approved HFS Amt –** Leave Blank **Begin Date –** If an item or service has already been dispensed, enter the date the item or service was provided. If the item will not be provided until the prior approval is granted, leave blank. **End Date** - Indicate the ending date of service, if applicable. **Pur/Rent** – Enter the appropriate code: P = Purchase R = Rental F = Repair M = Modification **Mod –** Leave blank.
Conditionally Required	**17-20**	To be used for additional procedures. If more than five procedures are listed, another request must be made.
Required	**21.**	**Additional Medical Necessity –** To be used for other medical information.
Not Required	22.	Approving Authority Signature
Required	**23.**	**Provider Signature/Date –** To be signed in ink by the individual who is to provide the service.

Instructions for Submittal

Before submission, carefully review the request for completeness and accuracy. The provider is to submit the form to the department as indicated below. The provider may wish to retain a copy in the provider's records.

The HFS 1409 may be faxed or mailed in pre-addressed mailing envelopes, Form HFS 2300, provided by the department.

Fax: 217-524-0099

Mailing address: Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Office Box 19124
Springfield, Illinois 62794-9105

A notification of the department's decision will be mailed to the provider. If the item is dispensed prior to the department's decision, the provider risks non-payment of the item.

Forms Requisition: The HFS 1409 form is available in a PDF-fillable format on the department's website. The HFS 2300 envelope may be requested on the website or by submitting a HFS 1517, as explained in Chapter 100.

Appendix M-4

Explanation of Information On Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider, and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date his or her signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic M-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet appears in Appendix M-4a.

Field	**Explanation**
Provider Key	This number uniquely identifies the provider, and is used internally by the department. It is directly linked to the reported NPI.
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the department's records. The three-digit **County** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state, if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information reflecting the manner in which the provider is enrolled with the department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

Field	Explanation
Enrollment Specifics	**Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Individual Practice 02 = Partnership 03 = Corporation **Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the department's Medical Programs. The possible codes are: B = Active I = Inactive N = Non Participating Disregard the term NOCOST if it appears in this item. Immediately following the enrollment status indicator are the **Begin** date, indicating when the provider was most recently enrolled in department's Medical Programs; and the **End** date, indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative, indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Intent to Terminate B = Expired License C = Citation D = Delinquent Child Support E = Provider Review F = Fraud Investigations G = Garnishment L = Student Loan Suspension R = Intent to Terminate/Recovery S = Exception Requested by Provider Participation Unit T = Tax Levy X = Suspensions If there is an exception indicator, it may affect the provider's activity with the department. If this item is blank, the provider has no exception.

Field	Explanation
Enrollment Specifics	Immediately following the **Exception Indicator** are the **Begin** date, indicating the first date when the provider's claims are to be manually reviewed; and the **End** date, indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.
Certification/ License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date, indicating when the license will expire.
S.S.#	This is the provider's Social Security or FEIN number.
Specialty and Categories of Service	This area identifies special licensure information, and the types of services a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. The possible codes are: 041 = Medical Equipment/Prosthetic Supplies 048 = Medical Supplies Each entry is followed by the date that the provider was approved to render services for each category listed.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC** # is the number assigned to the payee by the Medicare Carrier, to cross-over Medicare billable services. The PIN is the number assigned by Medicare to a provider within a group practice, if applicable.

Field	Explanation
NPI	The National Provider Identification Number contained in the department's database.
Signature	An original provider signature is required when the provider submits changes to the department.

Appendix M-4a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 02/05/15
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 02/05/15
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
436011111111

PROVIDER NAME AND ADDRESS

PROVIDER GENDER:
COUNTY 058-LASALLE
TELEPHONE NUMBER

D.E.A. #:
RE-ENRL IND: N DATE: 11/15/99

PROVIDER TYPE: 063 – EQUIP/NON-RG
ORGANIZATION TYPE: 03 – CORPORATION
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/15/99 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 331313131 ENDING 03/31/16
CLIA #: UPIN#:
LAST TRANSACTION ADD AS OF 04/21/14 S.S.#:331313131
CLIA#:

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	BEG DATE	REASON
041	MED EQUIP/PROSTHETIC DEVICES	11/15/99	048	MEDICAL SUPPLIES	11/15/99	

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	THE BANDAGE WAREHOUSE	1421 MY STREET	ANYTOWN	IL	62000	436011111-62000-01		11/15/99
	DBA:							
	MEDICARE/PIN: 6157302001					VENDOR ID: 30		

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
XXXXXXXXXX

********** PLEASE NOTE: *********

* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

Appendix M-5

Speech Generating Devices
Prior Approval Request Guidelines

Practitioner Prescription and Certification of Medical Necessity

The augmentative communication speech generating device must be prescribed by the patient's primary care practitioner. Medical necessity must be certified by the primary care practitioner. The certification must document the following:

- The individual lacks the ability to communicate with a practitioner or principal care giver in a manner sufficient to determine the person's care and treatment needs, to determine whether those needs have been met satisfactorily, to prevent or address an emergency medical need, and to prevent or address real or foreseeable injuries or impairments, and

- That intervention will correct a physical deformity or malfunction, or support a weak or deformed part of the body for the purpose of enhancing the individual's ability to communicate medical needs.

It is not required that the practitioner specify the type of device, since that will be determined from the assessment report.

Assessment Report

A patient assessment must be performed by a team led by a speech-language pathologist. The team must include the patient's primary care practitioner and parent (or primary care giver) and other licensed or board-certified medical professionals, as appropriate based on the patient's identified needs.

While there is no prescribed format for the assessment report, it must include the following information as it relates to the patient's ability to communicate:

A. A brief patient demographic and biographic summary including:
    - Diagnosis and reason for referral
    - Age
    - Approximate physical size
    - Living arrangement (with family and size and composition, in a Long Term Care or group facility, in a Supported Living facility, etc.)
    - Primary patient activities (e.g., school and grade level, employment and type, workshop or day treatment, stays at home) and
    - A list of other supportive resource individuals, if any (e.g., family members, friends, aide at school or work, in-home worker, facility staff).

B. An inventory of skill levels, sensory function, and use of assistive devices, if any, in the following areas:
   - Vision
   - Hearing
   - Ambulation mode(s), including seating and positioning, if applicable
   - Functional gross and fine motor skills in head and neck, trunk, and all four extremities
   - Cognition and learning potential, to include:
     Cause and effect (ability to associate certain behaviors or events with actions that will follow);
     Object permanence (ability to remember objects and realize they exist when they are not seen);
     Means end (ability to anticipate events independent of those currently in progress); and
     Cognitive level to include any available, recent standard or observational measurements of mental and developmental ages, and demonstrated consistent ability to attend, match, categorize, and sequence.

C. An inventory of present and future communication skill levels, to include the following:
   - Type of expressive communication method or mode(s) used
   - Functional level of oral, written and gestural expressive language capabilities, including oral motor speech status, and the communication functions of requesting, protesting, labeling and sharing information
   - Functional level of receptive communication skills, including language comprehension abilities
   - Communicative interest
   - Identification of a reliable and consistent motor response that can be used independently to communicate and
   - Skill level and use of any equipment aiding in communication including electronic tablets and phones

D. An explanation of present and future communication needs, including the types of communication needed, with whom and in what environments (for example, to enhance conversation or to write and signal emergency, basic care and related medical needs).

E. Features needed in patient communication system, as applicable:
   - Type and number of messages, vocabulary size, coding system, symbol sets, message retrieval
   - Size, layout, system memory, optical indicators, auditory prompts, rate enhancement, programmability, computer compatibility
   - Type of input method (for example, switches, mouth stick, head pointer, alternative keyboard, and direct selection, scanning, encoding)
   - Type of output (for example, speech, print, LCD, Braille)

- Mounting and portability
- Extent of training required to use the system and availability of training and technical assistance for its use
- Availability of customer service by manufacturer or supplier and
- Any other relevant considerations.

F. A summary of intervention options, to include:
   - A description of the systems tried by the patient during or prior to the assessment and
   - The advantages, disadvantages, cost, and availability of training and customer service, for the two or three most appropriate communication systems for the patient as determined through the assessment, specifying available features and patient needs for each.

G. Documentation of patient trial and success, including ability, motivation, independence, and improvement in communication effectiveness, in using one or more recommended communication systems, prior to or during the assessment.

H. The final recommendation of which system is most appropriate to meet the patient's medical needs and why.

The request must include documentation of a vendor's price quote, a copy of the warranty, the availability of maintenance, the shipping location, and a recommendation of at least one other system which would meet the patient's medical needs. Department approval will be made based on the most cost effective system that meets the individual's medical needs.

Individual Treatment and Implementation Plan

The individual treatment and implementation plan shall identify specific actions, objectives, time lines and the individual(s) responsible to carry out the plan, including programming the communication device, providing training in its use, and monitoring and following-up with the patient to assure appropriate utilization and effectiveness of the device to meet the individual's medical needs. The plan shall also identify the number of orientation or training sessions, and the individuals to be trained (for example, the patient, family, support staff, primary care givers) in the programming and operation of the communication device.

In some instances, when there is a doubt about the patient’s ability to use the device that is recommended, the Department may approve rental for a trial period. When a trial period is approved, a follow-up assessment from the therapist will be required if the trial period results in a request for purchase of the device.

Replacement, Modifications or Upgrades

Replacement, modification or upgrades of communication devices will require a complete assessment and will be subject to the Department's prior approval policy.

Replacements will be approved only if a device is not repairable, is destroyed or stolen, or no longer meets the individual's medical needs. Technological improvements and upgrades are not considered to be repairs and are subject to prior approval.

Appendix M-6

Items Provided by a Long Term Care Facility

Long Term Care (LTC) facilities are required to provide medical equipment, devices and supplies commonly used in patient care as a part of the per diem reimbursement paid to the facilities by the department. Such items include, but are not limited to, the following:

Adhesive Tape
Administration Equipment and Supplies for Parenteral Fluids-IV or Subcutaneous (excluding TPN solution and equipment)
Alcohol, Alcohol Swabs, Wipes
Antiseptics
Aspirator Bulbs
Atomizers
Band-aids
Bandages
Bedpans and Urinals
Blood Pressure Kits
Body Lotion
Brushes
Catheters
Combs
Comfort Lotions and Creams
Compression Stockings
Corn Starch
Cotton, Cotton Balls, Swabs
CPAP/BiPAP Machines
Cushions, Non-custom
Dental Floss
Denture Supplies
Deodorant or Antiperspirant
Diabetic Testing Supplies
Diapers, Disposable or Non-disposable
Disinfectants
Disposable Enemas
Drainage Tubing and Receptacles
Dressings
Durable Equipment, Non-custom (e.g., walkers, wheelchairs)
Dusting Powder
Elbow and Heel Protectors
Emesis Basins
Emollients
Enteral Therapy Equipment and Supplies
Eye Patches

Gauzes
Germicides
Hair Conditioner
Hearing Aid Batteries
Heat Lamps
Heavy Duty Equipment (non-custom)
Hot Water Bottles
Hydrogen Peroxide
Ice Bags
Irrigation Solutions
IV Poles and Supplies
Lubricating Jelly
Mattress Covers
Mouthwash
Mail Care Supplies
Nebulizers
Orthotics, Non-custom (e.g., helmets, elastic braces)
Oximeters and Oxygen Analyzers
Oxygen (1 “H” tank per resident per month) and Equipment/Supplies for Oxygen Administration
Pads (e.g., sheepskin, moleskin)
Petroleum Jelly (e.g., Vaseline)
Pressure Support Services
Razors
Rectal Tubes
Restraints
Rubber Gloves and Finger Cots
Sanitary Napkins and Related Items
Scissors
Shampoo, Non-prescription
Sharps Collectors
Shaving Cream
Soaps and Soap Substitutes
Suction Catheters
Suction Machine
Suppositories
Syringes and Needles
Talcum Powder
TENS Unit and Supplies
Thermometers
Tissues
Tongue Depressors
Toothbrush
Toothpaste
Towels
Trach Supplies including Trach Care Kits
Urological Supplies
Ventilators
Vinegar Douche

Appendix M-7

Internet Quick Reference Guide

The department's handbooks are designed for use via the Web and contain hyperlinks to the pertinent information. This appendix was developed to provide a reference guide for providers who print the department's handbooks and prefer to work from a paper copy.

Internet Site	Web Address
Healthcare and Family Services website	https://www.illinois.gov/hfs/Pages/default.aspx
Administrative Rules	http://www.ilga.gov/commission/jcar/admincode/titles.html
All Kids Program	https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/default.aspx
Care Coordination	https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx
Claims Processing System Issues	https://www.illinois.gov/hfs/MedicalProviders/SystemIssues/Pages/default.aspx
Child Support Enforcement	https://www.illinois.gov/hfs/ChildSupport/Pages/default.aspx
FamilyCare	https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/FamilyCare.aspx
Family Community Resource Centers	http://www.dhs.state.il.us/
Health Benefits for Workers with Disabilities	https://www.illinois.gov/hfs/medicalprograms/hbwd/Pages/default.aspx
Health Information Exchange	http://www.illinois.gov/sites/ILHIE/Pages/default.aspx
Home and Community Based Waiver Services	https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx
Illinois Health Connect	https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx
Illinois Veterans Care	https://www.illinois.gov/hfs/MedicalPrograms/vets/Pages/about.aspx
Illinois Warrior Assistance Program	http://www.illinoiswarrior.com/
Maternal and Child Health Promotion	https://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/default.aspx
Medical Electronic Data Interchange (MEDI)	https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx
State Chronic Renal Disease Program	https://www.illinois.gov/hfs/MedicalClients/renal/Pages/default.aspx
Medical Forms Requests	https://www.illinois.gov/hfs/MedicalProviders/Forms%20Request/Pages/default.aspx
Medical Programs Forms	https://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalformsnumeric.aspx
Non-Institutional Provider Resources	https://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx
Pharmacy Information	https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/default.aspx

Internet Site	Web Address
Provider Enrollment Information	https://www.illinois.gov/hfs/impact/Pages/default.aspx
Provider Fee Schedules	https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx
Provider Handbooks	https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx
Provider Releases	https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx
Registration for E-mail Notification	https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/ProviderEmailSubscribe.aspx
Place of Service Codes	http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
Centers for Medicare and Medicaid Services (CMS)	https://www.cms.gov/

Appendix M-8
Accessories and Supplies Included in Equipment Rental Reimbursement

Accessory/ Supply HCPCS Code	Description	COS	Associated Rental Item HCPCS Code
A4556	Electrodes, (e.g., apnea monitor) per pair	048	**E0619** - Apnea monitor, with recording feature
A4557	Lead Wires (e.g., apnea monitor) per pair	048	
A4558	Conductive paste or gel for use with electrical device (e.g., TENS/NMES) per oz.	048	**E0720** - Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation **E0730** - Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation **E0745** - Neuromuscular stimulator, electronic shock unit
A4595	Electrical stimulator supplies, 2 lead/month (e.g., TENS, NMES)	048	
A7000	Canister, disposable, used with suction pump, each	048	**E0600** - Respiratory suction pump, home model, portable or stationary, electric
A7002	Tubing, used with suction pump, each	048	
S8210	Mucous trap	048	
A4604	Tubing with integrated heating element for use with positive airway pressure device	041	**E0601** - Continuous airway pressure (CPAP) device **E0470** - Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device). **E0471** - Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device). **E0472** - Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device). **E0561** - Humidifier, non- heated, used with positive airway pressure device **E0562** - Humidifier, heated, used with positive airway pressure device
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	041	
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	041	
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	041	
A7030	Full face mask used with positive airway pressure device, each	041	
A7031	Face mask interface, replacement for full face mask, each	041	
A7032	Cushion for use on nasal mask interface, replacement only, each	041	
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	041	
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	041	
A7035	Headgear used with positive airway pressure device	041	
A7036	Chinstrap used with positive airway pressure device	041	
A7037	Tubing used with positive airway pressure device	041	
A7038	Filter, disposable, used with positive airway pressure device	048	
A7039	Filter, non-disposable, used with positive airway pressure device	041	
A7044	Oral interface used with positive airway pressure device, each	041	
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	048	
A7020	Interface For Cough Stimulating device, includes all components, replacement only	048	**E0482** - Cough Stimulating Device