Appendix H-2c

Completion	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Conditionally Required	**2.**	**Pay-To Name and Address** – Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**
Required	**4.**	**Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Optional	**10.**	**Patient Birth Date** - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.
Required	**18-28.**	**Condition Codes -** Identify the dialysis place of service. The department recognizes the following codes: 71-72, 74-76
Conditionally Required	**35-37.**	**Occurrence Span Code/From/Through** – When reporting non-covered days, providers must indicate the non-covered date span.

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=Conditionally Required ***Revised June 2016***	**39-41.**	**Value Codes -** The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter. Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim. Value Code 68 – The total units of Epogen must be reported using Value Code 68. Value Code 80 – The number of covered days is required for series claims. Value Codes applicable to Medicare deductible or coinsurance due.
=Required ***Revised Effective June 2016***	**42.**	**Revenue Code –** Enter the appropriate revenue code for the service provided. If billing series claims, providers must bill individual revenue lines for **each** dialysis service date. Providers may no longer bill one dialysis revenue line and identify multiple Service Units. The 23rd Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

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Required	**43.**	**Revenue Description -** NDC reporting of all drug codes is required. When a provider uses more than one NDC for a drug, the provider must include **all** NDCs on the claim. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting.
		
		• Report the N4 qualifier in the first two (2) positions, left- justified
		• Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
		• Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
		  • F2 – International Unit
		  • GR – Gram
		  • ML – Milliliter
		  • UN – Unit
		• Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal).
		• Any spaces unused for the quantity are left blank.

Required	**44.**	**HCPCS/Accommodation Rates –** Enter the corresponding HCPCS code associated with Revenue Lines 0634, 0635, or 0636. Hospitals are required to bill modifiers according to national coding guidelines. Modifier “UD” is required to denote all 340B-purchased drugs. Modifier “UD” must be the first modifier listed after the HCPCS procedure code.
=Required ***Revised Effective June 2016***	**45.**	**Service Date** – Dialysis revenue codes and injectable drug revenue codes 0634, 0635, and 0636 require a separate service line for each date of service.

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=Conditionally Required ***Revised Effective June 2016***	**46.**	**Service Units –** An entry is required to correspond to each renal dialysis revenue code. Also, an entry is required for claims containing Revenue Codes 0634 and 0635 for Epogen, or Revenue Code 0636 for specified renal dialysis injectable drugs or specified expensive drugs. Units should not be combined for multiple dates of service. Expensive drugs are only separately billable for dates of service through June 30, 2014.
Required	**47.**	**Total Charges** (By Revenue Code category) For dates of service beginning February 1, 2013, providers may add a $12.00 dispensing fee to the actual acquisition cost for a drug from the Renal Dialysis Injectable Drug Listing if that drug is 340B-purchased. For Revenue Code 0001, see FL 42 above.
Conditionally Required	**48.**	**Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.
Required	**50.**	**Payer** - Illinois Medicaid or 98916 must be shown as the payer of last resort.