Practitioner Services- Appendices

Table of Contents

Appendix A-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2360 (pdf), Health Insurance Claim Form

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 practitioner.
- 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/font size 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 only black ink for entries on the billing form, attachments and practitioner 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.

A sample of the HFS 2360 (pdf) may be found on the Department's Web site. Instructions for completion of this claim follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for the 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 practitioner services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Patient's Name** - Enter the participant's name exactly as it appears on the Identification Card or Notice. Separate the components of the name (first, middle initial, last) in the proper order of the name field.
Optional	**2.**	**Patient's Date of Birth** - Enter the month, day and year of birth of the patient as shown on the Identification Card or Notice issued by the Department. Use the MMDDYY format. If the birthdate is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birthdate is not entered, the Department will not attempt corrections. Age – leave blank.
Not Required	3. – 7.	Leave blank.
Required	**8.**	**Medicaid Number** – Enter the nine-digit number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Not Required	9.	Other Health Insurance Coverage – Leave blank.
Conditionally Required	**10.**	**Was Condition Related to** – If the patient sought treatment for an injury or illness that resulted from employment, type a capital "X" in the Yes box under A, Patient's Employment. If the patient sought treatment for an injury or a condition that resulted from an automobile accident, type a capital "X" in Field 10B, AUTO. If the place of service billed is for Emergency Department Services, type a capital "X" in Field 10B, OTHER.

Completion	Item	Explanation and Instructions
Not Required	11.	Insured's Address – Leave blank.
Required	**12.**	**Recipient's or Authorized Person's Signature** – The participant or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Not Required	13.	Leave blank.
Conditionally Required	**14.**	**For prenatal services, enter the date of the Last Menstrual Period (LMP).** Use MMDDYY format.
Not Required	15.	Leave blank.
Conditionally Required	**16.**	**Check here if emergency.**
Not Required	17. – 18.	Leave blank.
Conditionally Required	**19.**	**Name of Referring Practitioner or Other Source** – This field is required when charges are being submitted for a **consultation**. Additionally, a referring practitioner's name is always required when a referring practitioner NPI is entered. **Referring Practitioner Number** – The referring practitioner number is always required when a referring practitioner name is entered. Enter the referring practitioner's NPI.
Not Required	20.	Leave blank
Conditionally Required	**21.**	**Facility Where Services Rendered** - This entry is required when Place of Service Code in Field 24B is other than 11 (office) or 12 (home). Address may be abbreviated.
Not Required	22.	Leave blank.
Conditionally Required	**23A.**	**Healthy Kids Services** - If services rendered were Healthy Kids services, enter a capital X in the Yes box.
Conditionally Required	**23B.**	**Family Planning** - If services were rendered for family planning purposes, enter a capital X in the Yes box.

Completion	Item	Explanation and Instructions
Conditionally Required	**23C.**	**Sterilization/Abortion** - If services rendered were for a Sterilization or Abortion, enter a capital X in the Yes box. When the service is being submitted for payment for an abortion, a completed copy of the HFS 2390 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope. When the service is being submitted for payment for sterilization, a completed copy of the HFS 2189 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope. When the service is being submitted for payment for a hysterectomy, a completed copy of HFS 1977 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope.
Not Required	23D.	Prior Approval – Leave blank.
Required	**23E.**	**T.O.S. (Type of Service)** – Enter the code corresponding to the type of service for which the charges submitted on the claim apply. Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. The following are the Type of Service Codes acceptable by the Department. 1 Medical Care – Attending Physician or Concurrent Care. 2 Surgery – Surgeon, Assistant Surgeon or Co-Surgeon. 3 Consultation – Consultant. 4 Diagnostic X-Ray – Radiologist. 5 Diagnostic Laboratory – Pathologist. 6 Anesthesia – Anesthesiologist, CRNA. 7 Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon.
Optional	**23F.**	**Diagnosis or Nature of Injury or Illness** – Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient's treatment. A written description is not required if a valid ICD-10 Code is entered in Item 24D.
Optional	**24.**	**Repeat** – The practitioner may use the repeat indicator to complete the same data fields in multiple service sections. All information other than the date of service must remain the same as the previous service section. The actual date of service must be entered in every service section. When the repeat box is necessary, enter a capital "X." Any other character will be ignored. The repeat indicator cannot be used immediately following a service section which has been deleted.
Required	**24A.**	**Date of Service** - Enter the date the service was rendered. Use MMDDYY format.
Required	**24B.**	**P.O.S. (Place of Service)** – Enter the 2-digit code corresponding to the appropriate place of service.

Completion	Item	Explanation and Instructions
Required	**24C.**	**Procedure Code/Drug Item No.** - Enter the appropriate procedure code or NDC. Refer to Appendix A-7 for information regarding NDC billing.
Conditionally Required	**24C.**	**MOD** – Enter the appropriate two-character modifier for the service performed. A listing of the modifiers recognized in processing HFS claims may be found on the modifier listing for practitioner claims.
Required	**24D.**	**Primary Diagnosis Code** – Enter the specific ICD-10 Code without the punctuation or spaces for the primary diagnosis.
Optional	**24D.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered. Enter only a specific ICD-10 Code without the punctuation or spaces.
Required	**24E.**	**Charges** – Enter the total charge, in both dollars and cents, for the service. Do not deduct any Third Party Liability payments or copayments from these charges.
Required	**24F.**	**Days/Units** – Unless otherwise stated or allowed enter a quantity of "0001." A four-digit entry other than "0001" is required for the following: • **Anesthesia Service**, enter the duration of time in minutes; e.g., the entry for 1 hour and 10 minutes is 0070. • **Assistant Surgeon services** enter the duration of time in minutes; e.g., the entry for 1 hour and 10 minutes is 0070. • When **mileage** is charged, enter the total number of miles one way; e.g., the entry for 32 miles is 0032. • When billing for **multiples** refer to the practitioner fee schedule key.
Optional		**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	**25.**	**Signature of Physician and Date Signed** - After reading the certification statement printed on the back of the claim form, the practitioner or authorized biller (practitioner's name followed by biller's initials) must sign the completed form. **The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable.** Unsigned claims will not be accepted by the Department and will be returned to the practitioner when possible. The date of the practitioner's signature is to be entered in the MMDDYY format. The practitioner's signature should not enter the date section of this field.

Completion	Item	Explanation and Instructions
Required	**26.**	**Accept Assignment** – The practitioner must accept assignment of Medicare benefits for services provided to participants. Enter a capital “X” in the "Yes" box.
Required	**27.**	**Total Charges** - Enter the sum of all charges submitted on the claim in service section 1 through 7. Do not include charges for any deleted sections.
Required	**28.**	**Amount Paid** - Enter the sum of all payments received from other sources. The entry must equal the sum of the amounts as shown in fields 37C and 38C, TPL Amount. If no payment was received enter three zeroes (000). Do not collect primary copayments on Medicaid secondary claims. Do not include HFS copayments or amount previously paid by the Department as primary payment.
Required	**29.**	**Balance Due** - Enter the difference between Total Charges and Amount Paid.
Required	**30.**	**Your Provider Number** – Enter the rendering practitioner’s **NPI**.
Required	**31.**	**Provider Name, Address, ZIP Code** – Enter the practitioner’s name exactly as it appears on the Provider Information Sheet. Enter the street address of the practitioner. If an address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If an address is not entered, the Department will not attempt to make corrections. Enter city, state and zip code of practitioner.
Optional	**32.**	**Your Patient's Account Number** - Enter up to 20 numbers or letters used in your accounting system for identification. If this field is completed, the same data will be reported on the HFS 194-M-2, Remittance Advice.
Required	**33.**	**Your Payee Code** – Enter the one-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**34.**	**Number of Sections** - Enter the number of service lines correctly completed above in Section 24. Do not include **deleted** sections.
Not Required	35. - 36.	Leave blank.

Completion	Item	Explanation and Instructions
Conditionally Required	**37A.**	**TPL Code** – If the patient's Identification Card contains a TPL Code, the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in 38A. – 38D. **Do not attach a copy of the TPL Explanation of Benefits (EOB).** Practitioners providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a patient's private insurance carrier prior to billing the Department for these services. **Do not report Medicare Information in the TPL fields.** Refer to Appendix A-2 for information regarding Medicare crossovers. For Medicare denied services with an additional TPL resource involved, please report the following: • Do not report the Medicare information in the TPL field. • Do attach a copy of the Medicare EOB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOB. **Spenddown** – Refer to Chapter 100, Topic 113 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 participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant 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 participant 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.

Completion	Item	Explanation and Instructions
Conditionally Required	**37A. (cont.)**	If the HFS 2432 shows a participant liability of 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 participant 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 participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant 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. Enter in MMDDYY format. If the HFS 2432 shows a participant 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. Enter 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. Enter 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	Explanation and Instructions
Conditionally Required	**37B.**	**TPL Status** – If a TPL Code is shown, 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 practitioner 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 practitioner 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 HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner 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 from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**37C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Completion	Item	Explanation and Instructions
Conditionally Required	**37D.**	**TPL Date** – A TPL date is required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status 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, Split Bill Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Conditionally Required	**38A.**	**TPL Code** – (See 37A above).
Conditionally Required	**38B.**	**TPL Status** – (See 37B above).
Conditionally Required	**38C.**	**TPL Amount** – (See 37C above).
Conditionally Required	**38D.**	**TPL Date** – (See 37D above).

Mailing Instructions

The Health Insurance Claim Form is a single page or two-part form. The practitioner is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part form should be removed prior to submission to the Department. The practitioner should retain a copy of the claim. Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the Department.

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

Non-routine claims (claims with attachments, such as Medicare denial EOMB or HFS 2432, Split Billing Transmittal submitted with a one page claim) are to be mailed to the Department in pre-addressed mailing envelope, HFS 1414, Special Approval Envelope, which is provided by the Department for this purpose.

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

Non-routine claims, HFS 2432, Split Billing Transmittal submitted with multiple claims are to be mailed to the Department for special handling.

Mailing address: Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115

Forms Requisition - Billing forms may be requested on our Web site or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix A-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 practitioner.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the practitioner.
- 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/font size 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 only black ink for entries on the billing form, attachments and practitioner 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 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.
- Print in the gray area of attachments, either as part of the original or as a result of photocopying a colored background, 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 the back of the 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 the HFS 3797 (pdf) may be found on the Department's Web site. 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 appropriate HFS Medicaid form and attach the Explanation of Medicare Benefits to the claim.** Refer to Appendix A-2 for billing and mailing information.

The left hand column of the following instructions identifies mandatory and optional items for the 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.

Completion	Item	Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the appropriate box, using the following guideline when determining claim type: 23 - Practitioner - physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers 24 - Dental - dental providers 25 - Lab/Port X-Ray - all laboratories and portable X-ray providers 26 - Med. Equip/Supply - medical equipment and supply providers, pharmacies 28 – Transportation - ambulance service providers If provider type is not indicated above, enter a capital "X" in the Practitioner box.
Required	**1.**	**Recipient's Name** - Enter the participant'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	Explanation and Instructions
Conditionally Required	**4.** **A.** **B.**	**Was Condition Related to** – Participant's Employment - Treatment for an injury or illness that resulted from participant's employment, enter a capital "X" in the "Yes" box. 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 participant or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Conditionally Required	**9.**	**Other Health Insurance Information** - If the participant has an additional health benefit plan (other than Medicare or Medicaid), 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. Using the MMDDYY format enter the same date in both the "From" and "To" fields.
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS Code submitted to Medicare.
Required	**10C.**	**T.O.S. (Type of Service)** – Enter TOS as submitted to Medicare. The following are the Type of Service Codes acceptable by the Department. 1 Medical Care – Attending Physician or Concurrent Care. 2 Surgery – Surgeon, Assistant Surgeon or Co-Surgeon. 3 Consultation – Consultant. 4 Diagnostic X-Ray – Radiologist. 5 Diagnostic Laboratory – Pathologist. 6 Anesthesia – Anesthesiologist, CRNA. 7 Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon.

Completion	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. Mileage – Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032. Anesthesia or Assistant Surgery Services – Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 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 service(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
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 practitioner was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Conditionally Required	**11.**	**For NDC Use Only** – Required when billing NDC Codes for practitioner purchased and administered injectable medication.
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS or CPT 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.
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.

Completion	Item	Explanation and Instructions
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 the HFS 194-M-2, Remittance Advice, returned to the practitioner.
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-10-CM Code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the valid ICD-10-CM Diagnosis Code without punctuation or spaces for the services rendered.
Optional	**18B.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-10-CM Diagnosis Code without punctuation or spaces.
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 practitioner's office or participant's home. Enter the facility name and address where the service(s) was rendered. When the name and address of the facility where the services were rendered is the same as the biller's name and address as submitted in Field 22, enter the word "Same."
Required	**21.**	**Accept Assignment** – The practitioner must accept assignment of Medicare benefits for services provided to participants for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box.
Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the practitioner/supplier name exactly as it appears on the Provider Information Sheet to the right of the "Provider Key."
Required	**23.**	**HFS Provider Number** – Enter the rendering provider's NPI.

Completion	Item	Explanation and Instructions
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 – Leave blank.
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy Code. Refer to Chapter 300.
Conditionally Required	**29A.**	**TPL Code** – If the patient's Identification Card contains a TPL Code, the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in Fields 30A – 30D. **Do not report Medicare information in the TPL fields.** **Spenddown** – Refer to Chapter 100 (pdf) 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.

Completion	Item	Explanation and Instructions
Conditionally Required	**29A. (cont.)**	If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant 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 participant 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 participant liability of 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 participant 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 participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant 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	Explanation and Instructions
Conditionally Required	**29A. (cont.)**	If the HFS 2432 shows a participant 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.
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 practitioner 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 practitioner 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 HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force.

Completion	Item	Explanation and Instructions
Conditionally Required	**29B. (cont.)**	**06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner 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 from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**29C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. 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, Split Billing Transmittal 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).

Completion	Item	Explanation and Instructions
Required	**31.**	**Provider Signature** - After reading the certification statement printed on the back of the claim form, the practitioner or authorized representative must sign the completed form. The signature must be handwritten in black or blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the practitioner. The practitioner's signature should not enter the date section of this field.
Required	**32.**	**Date** – The date of the practitioner's signature is to be entered in the MMDDYY format.

Mailing Instructions

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

Routine claims are to be mailed to the Department in the pre-addressed mailing envelopes, HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department. Should envelopes be unavailable, the HFS 3797 can be mailed to:

Mailing address: Medicare Crossover Invoice
Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Non-routine claims (multiple claims submitted with an HFS 2432, Split Bill Transmittal) must be mailed to the Department for special handling.

Mailing address: Healthcare and Family Services
PO Box 19115
Springfield, Illinois 62794-9115

Do not bend or fold claims prior to submission. Do not attach EOMB to claim.

Forms Requisition - Billing forms may be requested on our Web site or by submitting a HFS 1517 as explained in Chapter 100 (pdf), General Appendix 10.

Appendix A-3
Preparation and Mailing Instructions for Form HFS 1409 (pdf), Prior Approval Request

Form HFS 1409 (pdf), Prior Approval Request, revision date (R 03-09) 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 this handbook.

A sample of Form HFS 1409 (pdf), Prior Approval Request may be found 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.

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	Explanation and Instructions
Required	**1.**	**Recipient ID Number** – Enter the nine-digit recipient identification number assigned to the patient for whom the service or item is requested. This number is found to the right of the patient's name on the back of the Identification Card.
Required	**2.**	**Recipient Name** - Enter the name of the patient for whom the service or item is requested.
Required	**3.**	**Birthdate** - Enter the patient's birthdate.
Required	**4.**	**Provider/NPI #** - Enter the provider number or NPI number as shown on the Provider Information Sheet.
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 provider who will provide the service or item.

Completion	Item	Explanation and Instructions
Required	**7.**	**Physician Name** – Enter the name of the physician or other practitioner who signed the order recommending that the patient receive the specific service.
Required	**8.**	**Provider Street Address** – Enter the address of the provider.
Required	**9.**	**Physician Street Address** – Enter the address of the ordering practitioner.
Required	**10.**	**Provider City, State ZIP Code** – Enter the address of the provider.
Required	**11.**	**Physician City, State, ZIP Code** – Enter the address of the ordering practitioner.
Required	**12.**	**Diagnosis Code** – Enter the ICD-10-CM, diagnosis code that corresponds to the description listed in item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis** – Enter additional ICD-10-CM, diagnosis codes, if applicable.
Required	**14.**	**Diagnosis Description** – Enter the written description, which corresponds with the diagnosis code listed in item 12.
Required	**15.**	**Patient Height/Weight** – Enter patient's height and weight.
Required	**16.**	**Procedure Code** – Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested.
Required		**Description – Briefly describe the services to be provided.**
Required		**Qty – Enter the number of times the service is to be performed.**
Required		**Cat. Serv – Enter the two-digit category of service corresponding to the service.**
Required		**Prov Charge – Enter the total amount to be charged for the service being requested.**
Not Required		Approved HFS Amt – Leave blank.
Conditionally Required		**Begin Date – If a service has already been provided, enter the date the service was provided. If service will not be provided until the prior approval is granted, leave blank.**
Conditionally Required		**End Date – Indicate the ending date of service, if applicable.**
Not Required		Pur/Rent – Leave blank.

Completion	Item	Explanation and Instructions
Not Required		Mod – To be used for modifiers at a later date.
Conditionally Required	**17-20**	To be used for additional procedures. If you list more than five (5) procedures another request must be submitted.
Conditionally Required	**21.**	**Additional Medical Necessity** – To be used for other medical information.
Not Required	22.	Approving Authority Signature – Leave blank.
Required	**23.**	**Provider Signature/Date** – To be signed in ink by the individual who is to provide the service.

Mailing Instructions

Before mailing, carefully review the request for completeness and accuracy. The signed copy of the HFS 1409 (pdf) may be mailed to:

Mailing Address: Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124

A copy may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider and patient.

FAX INSTRUCTIONS
The signed copy of the HFS 1409 (pdf) may be faxed Monday through Friday, 8:30 AM – 5:00 PM, excepting holidays, to the following number 217-524-0099.

Appendix A-4

Completion of Form HFS 1977 (pdf)
Acknowledgment of Receipt of Hysterectomy Information

Part I

Item	Instructions
Recipient Name	Must be participant's first and last name.
Recipient Identification No.	Must be the participant's nine (9) digit identification number. The number must match participant number on claim.
Physician name	Must be completed with practitioner's name and match Physician's Signature on this form.
Provider No.	Enter the practitioner's NPI.

Part II

Item	Instructions
Acknowledgement	Enter the participant's first and last name.
Recipient or Representative Signature	Recipient's Signature – Must match Recipient Name. Representative Signature – Any signature is acceptable.
Date	Must be completed in the MMDDYY format.
Interpreter Signature	If applicable, an original signature is required.
Date	Must be completed if there is an Interpreter Signature.

Part III

Item	Instructions
Physician Signature	Must be an original signature. Stamped signatures are not acceptable.
Date	Must be completed in the MMDDYY format.

Part IV
Exception Request
Exception #1: The cause of sterility must be stated.

Exception #2: The life threatening emergency situation must be indicated.

Exception #3: The date of surgery must be entered. The date of the procedure must match the date of service on the claim.

If an Exception Request is completed, all items in Part I must be properly completed. The participant signature is not required. The Physician's Signature and Date are required.

Appendix A-5

Completion of Form HFS 2189
Sterilization Consent Form

To facilitate processing a claim to which the attachment of Form HFS 2189 (pdf) is required, all sections must be completed. The terminology regarding the sterilization should be consistent throughout the consent form.

Consent to Sterilization

Completion	Instructions
Required	Physician or clinic name - Must be the name of the practitioner or clinic responsible for giving the participant the required information regarding sterilization.
Required	Name of sterilization operation - Must match the sterilization listed on the claim.
Required	Recipient's birth date - Must be the participant's birth date as listed on the claim in MMDDYY format.
Required	Recipient's name - Must be participant's name. Must match participant's name on claim and other entries for participant name on this form.
Required	Physician's name - Must be name of practitioner or clinic that performed sterilization.
Required	Sterilization Method - Must match the sterilization listed on the claim.
Required	Recipient's signature - Must be participant's full first and last name. Must match name on claim and be an original signature in black or blue ink. Hand-printed signature is acceptable.

Required	Date consent form signed by participant - Must be the date that the participant signed the consent form.
	• Must be at least 72 hours prior to date of sterilization as listed on claim and physician statement on consent form. **No Exceptions**
	• Must be more than 30, but less than 180 days prior to date of sterilization.
	• If less than 30 days:
	  • Practitioner must give explanation as outlined in final paragraph of consent form – giving either the participant's original expected delivery date or an explanation of the emergency abdominal surgery.
	  • When premature delivery is checked, the original expected date must be more than 30, but less than 180 days after consent form was signed.

Optional	Race and Ethnicity Designation

Interpreter's Statement

Completion	Instructions
Conditionally Required	Interpreter's statement - Must specify the language into which the sterilization information has been translated.
Conditionally Required	Interpreter's signature - Must be interpreter's name and an original signature in black or blue ink. Printed signature is acceptable.
Conditionally Required	Date of interpreter's statement - Must be completed if there is an interpreter's signature in MMDDYY format.

Statement of Person Obtaining Consent

Completion	Instructions
Required	Name of individual - Must be the participant's name. Must match name on claim.
Required	Sterilization Operation - Must match the sterilization procedure listed on the claim.
Required	Signature of person obtaining consent - Must be an original signature in black or blue ink.
Required	Date consent was obtained - Must be a date in MMDDYY format.
Required	Facility - Must refer to the location of the practitioner or clinic obtaining the consent.
Required	Facility address - Must refer to the location of the practitioner or clinic obtaining the consent.

Physician's Statement

Completion	Instructions
Required	Name of individual to be sterilized - Must be the participant's name. Must match the name on the claim.
Required	Date of sterilization - Must match the date of sterilization listed on claim in MMDDYY format.
Required	Type of operation - Must match sterilization listed on claim.
Required	Physician's signature – Must be an original signature in black or blue ink of practitioner who performed the sterilization procedure. No stamped signatures are acceptable.
Required	Date - Date of practitioner's signature. Must be either the same date as the participant's consent or later and in MMDDYY format.

Appendix A-6

Completion of Form HFS 2390 (pdf)
Abortion Payment Application

If any of the following items are not completed as outlined below, the claim and the Payment Application form will be returned to the practitioner. Entries must be typed or printed in black ink.

Participant Information

Item	Instructions
Recipient Name	Must be the participant's first and last name.
Recipient Address	Must be completed with participant's address.
Case Identification No.	Must be completed with participant's case identification number as shown on the identification card.
Recipient Identification No.	Must be completed with the recipient's 9-digit I.D. number. Must match the recipient's I.D. number on the claim.

Facility/Procedure Information

Item	Instructions
Date	Must be the date the service was performed in MMDDYY format.
Abortion Reason	Check the box for the appropriate reason and type of procedure performed. Must match procedure code on the claim. Mifepristone is to be checked for non-surgical abortions.

Physician Statement

Item	Instructions
Medicaid Provider Number	Enter the practitioner's NPI.
Street Address	Enter the practitioner's office street address.
City, State, ZIP	Enter the practitioner's office city, state and ZIP Code.
Signature of Physician Performing Abortion	Must be an original signature of the practitioner who performed the abortion. No stamped signatures are acceptable.
Date	Enter the date the practitioner signed the application in MMDDYY format.

Appendix A-7

Julian Date Calendar (Perpetual)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

Julian Date Calendar (Leap Years)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

Appendix A-8
NDC Billing Instructions

The Health Insurance Portability and Accountability Act (HIPAA) standard code set for NDCs is eleven digits. The first segment must include five digits, the second segment must include four digits, and the third segment must include two digits (5-4-2 configuration). For example, 12345-1234-12 is a correctly configured NDC. However, the NDC on the product label might not contain 11 digits. The labeler may have dropped leading zeros in a segment. In this situation, the appropriate number of leading zeros must be added at the beginning of each segment to ensure that the NDC is shown in the 5-4-2 format. Where the zero is added depends upon the configuration of the NDC.

The following table provides examples of incorrectly configured NDCs and the corresponding correctly configured NDC. The segment that is missing the leading zero is bolded in each example.

NDC on Label	Configuration on Label	NDC in Required 5-4-2 Format
05678-**123**-01	5-3-2	05678-0123-01
5678-0123-01	4-4-2	05678-0123-01
05678-0123-**1**	5-4-1	05678-0123-01

The following provides NDC billing instructions.

HIPAA 837P Transactions and Direct Data Entry through the MEDI System
For HIPAA 837P electronic claim transactions, the HCPCS Code is reported in Loop ID 2400 and the NDC is reported in Loop ID 2410. For more detailed information please refer to the billing instructions for electronic claim transactions found in Chapter 300 (pdf). Providers registered to bill through the Direct Data Entry MEDI System can access instructions for the specific claim format [HFS 2360 (pdf), HFS 1443 (pdf)].

Paper Transactions
The HCPCS Code with the charge and the appropriate quantity based on the HCPCS definition should be billed on one service line on the HFS 2360 (pdf). The corresponding NDC must always be reported on the service line directly after the drug HCPCS Code service line. The NDC service line(s) must include the date of service, place of service, NDC Code without dashes, and NDC charge amount of zero. On the HFS 3797 (pdf), the corresponding NDC must be reported in Section 11.

Reporting Quantities

These instructions apply to both paper claims and electronic transactions.

At this time, the Department will use only the HCPCS quantities/units for payment and rebate purposes.

When a provider uses more than one NDC of a drug, the provider must include all NDCs on the claim. The quantity for **each** NDC must be reported separately by repeating the HCPCS Code. Please refer to the **Reporting of Multiple NDCs** section.

Reporting Charges

These instructions apply to both paper claims and electronic transactions.

The provider's charge must be reported for each HCPCS Code. A charge of zero should be reported for each NDC.

Reporting Multiple NDCs
These instructions apply to both paper claims and electronic transactions.

At times, it may be necessary for providers to bill multiple NDCs for a single procedure code. This may happen when two different strengths of the same drug are needed in order to administer the appropriate dose. This will also be necessary when multiple vials of the same drug are used to administer the appropriate dose, and different manufacturers manufacture the vials. Modifiers 76 and 51 are to be submitted as necessary. Refer to the billing examples below and the modifier listing for practitioner claims.

Billing examples of these situations are provided below. The examples apply to both paper claims and electronic transactions.

Procedure for billing one HCPCS and multiple NDCs:

Service Line 1 or Loop 2400:	HCPCS Code Report HCPCS quantity associated with NDC in Service Line 2
Service Line 2 or Loop 2410:	NDC associated with Service Line 1
Service Line 3 or Loop 2400:	HCPCS Code (same as Service Line 1) - Modifier 76 (Repeat Procedure) Report HCPCS quantity associated with NDC in Service Line 4
Service Line 4 or Loop 2410:	NDC associated with Service Line 3
Service Line 5 or Loop 2400:	HCPCS Code (same as Service Line 1 & 3) - Modifier 51 (Multiple Procedures) Report HCPCS quantity associated with NDC in Service Line 6
Service Line 6 or Loop 2410:	NDC associated with Service Line 5

Example 1: Procedure for billing **three (3)** 250 mg vials of ceftriaxone manufactured by two different manufacturers.

Provider will bill **a total quantity of** three (3) HCPCS procedure code units, but will divide those units, as follows:

Service Line 1 or Loop 2400:	J0696 billed with a quantity of 2
Service Line 2 or Loop 2410:	00781320695
Service Line 3 or Loop 2400:	J0696 and modifier 76 billed with a quantity of 1
Service Line 4 or Loop 2410:	00409733701

Reporting Multiple NDCs – Example 1

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0696		Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	Two (2) 250 mg vials	2	00781320695 ceftriaxone 250 mg vial manufactured by Sandoz
J0696	76	Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	One (1) 250 mg vials	1	00409733701 ceftriaxone 250 mg vial manufactured by Hospira

Example 2: Procedure for billing 125 mcg of Aranesp (darbepoetin alfa) using two different vials/strengths of the drug: one (1) 25 mcg syringe and one (1) 100 mcg syringe.

Provider will bill **a total quantity of** 125 HCPCS procedure code units, but will divide those units, as follows:
Service Line 1 or Loop 2400: J0881 billed with a quantity of 25
Service Line 2 or Loop 2410: 55513005704
Service Line 3 or Loop 2400: J0881 with modifier 76 billed with a quantity of 100
Service Line 4 or Loop 2410: 55513002504

Reporting Multiple NDCs - Example 2

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0881		Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 25 mcg/ 0.42 ml syringe	25	55513005704 Aranesp 25 mcg/0.42 ml syringe
J0881	76	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 100 mcg/ 0.5 ml syringe	100	55513002504 Aranesp 100 mcg/0.5 ml syringe

Hand Priced Drug Procedure Codes

These instructions apply to both paper claims and electronic transactions. Providers must report both the HCPCS Code and NDC for drugs requiring hand pricing. These procedure codes are identified on the Practitioner Fee Schedule. Providers must report the HCPCS Code in the procedure field, and the product name, strength and the dosage administered or dispensed in the description field. The description field is Box 24C on the paper HFS 2360 claim, the "procedure literal description" field for DDE claims, or the NTE segment of Loop 2400 for electronic transactions. On paper claims only, the quantity in the units field must be 1. In the service line immediately following, providers must report the NDC as the procedure code and charge amount as "0."

Appendix A-9

Vaccination Billing Instructions Fee-for-Service (FFS)

Children 0 to 18 years of age (Title XIX [19] Only)

EXAMPLE #1
A Well-Child examination and routine vaccinations are administered in a setting other than an encounter rate clinic. Bill the examination/visit using the appropriate CPT procedure code and bill the specific vaccine procedure codes.

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific VFC-provided vaccine	Per fee schedule ***Unit Price*** field
90xxx	Specific non-VFC vaccine (if applicable)	Per fee schedule ***State Max*** field

EXAMPLE #2
A child presents solely to receive a vaccine in a setting other than an encounter rate clinic. The salaried staff member administers the VFC vaccine or private stock vaccine. Bill the appropriate minimal level office visit or other outpatient visit for evaluation and management not requiring the presence of a physician and bill the specific vaccine procedure codes.

Procedure Code	Description	Reimbursement Rate
99211	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific VFC-provided vaccine	Per fee schedule ***Unit Price*** field
90xxx	Specific non-VFC vaccine (if applicable)	Per fee schedule ***State Max*** field

Children 0 through 18 years of age (Title XXI [21] & State-Funded) and Adults +19 years of age

EXAMPLE #3
A Well-Child examination is performed and routine vaccinations are administered in a setting other than an encounter rate clinic. Bill the examination/visit using the appropriate CPT procedure code and bill the vaccine using the specific vaccine-(s) CPT procedure codes.

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific non-VFC vaccine	Per fee schedule ***State Max*** field

EXAMPLE #4
A patient presents solely to receive a vaccine in a setting other than an encounter rate clinic. The salaried staff member administers the private stock vaccine. Bill the appropriate minimal level office visit or other outpatient visit for evaluation and management not requiring the presence of a physician and bill the specific vaccine procedure codes.

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific non-VFC vaccine	Per fee schedule ***State Max*** field

Appendix A-10

Telehealth Billing Examples

Billing Examples for Telemedicine Services

Example 1: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Podiatrist's office
Bill the appropriate CPT Code with modifier GT.
Reimbursement will be the fee schedule rate for the CPT Code billed.

Example 2: **Originating Site – Local Health Department**
Bill HCPCS Code Q3014

Distant Site – APN's office
Bill the appropriate CPT Code with modifier GT.
Reimbursement will be the fee schedule rate for the CPT Code billed.

Example 3: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Local Health Department
Not a valid provider – there is no billable service.

Example 4: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.

Example 5: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.

Example 6: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate. The rendering provider's name and NPI must also be reported on the claim.

Billing Examples for Telepsychiatry Services

Example 1: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Physician who has completed an approved general or child/adolescent psychiatry residency program
Bill the appropriate CPT Code for services provided.
Reimbursement will be the fee schedule rate for the CPT Code billed.

Example 2: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program.

Example 3: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program.
Reimbursement will be the facility's medical encounter rate.

Example 4: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program.

Appendix A-11

Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is initially enrolled in the Department's Medical Assistance Program. It is also generated, in most instances, when there has been a change or update to a provider's enrollment record.

Provider Information Sheets are mailed to the provider as well as to all payees/Billing Providers on file. This sheet should serve as a record of the data on the Department's databases.

If the provider notes that the Provider Information Sheet does not reflect accurate data, the provider should submit corrected information using the IMPACT system. If all the information on the sheet is correct, the provider should retain the document and reference it as needed, such as when completing any Department forms.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix A-10a.

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 concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative, which indicates the provider's classification. **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 04 = Group Practice

Field	Explanation
Enrollment Specifics	**Enrollment Status** is a one-digit code and corresponding narrative, which 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 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 = Exception Requested by Audits C = Citation to Discover Assets G = Garnishment T = Tax Levy If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** is 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. **AGR** (Agreement) indicates whether the provider has agreed to the Terms & Conditions in IMPACT.
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.

Field	Explanation
Categories of Service	This area identifies special licensure information and the types of service 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 practitioner is authorized to render to patients covered under the Department's Medical Programs. The possible codes are: 001 – Physician Services 006 – Physician Psychiatric Services 010 – Nursing Services 017 – Anesthesia Services 018 – Midwife Services 026 – Encounter Rate Clinic Services 030 – Healthy Kids Screening Services 045 – Optical Materials 057 – Nurse Practitioner 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. **If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.** **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 crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
NPI	The National Provider Identification Number contained in the Department's database.

Appendix A-11a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 1/10/15
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 1/10/15
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
036999999

PROVIDER NAME AND ADDRESS
JOHNSON ALBERT
1421 MY STREET
ANYTOWN, IL 62000

PROVIDER GENDER:
COUNTY 200-COOK
TELEPHONE NUMBER - -

PROVIDER TYPE: 010 – PHYSICIAN
ORGANIZATION TYPE: 01 – INDIVIUAL PRACT
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/01/14 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 036999999 ENDING 01/31/16
PHARMACY AFFIL: 03 – GROUP PRACTICE CLIA #:
LAST TRANSACTION ADD AS OF 01/14/14
NCPDP #:

D.E.A.#: AA1234567
RE-ENROLLMENT INDICATOR: E DATE: 11/15/14

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

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
001	PHYSICIAN SERVICES	11/01/14	006	PHYSICIAN PSYCHIATRIC SERVICES	11/01/14	
017	ANESTHESIA	11/01/14	030	HEALTHY KIDS SCREENING SERVICES	11/06/14	

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ANYTOWN MEDICAL ASSOC	1421 MY STREET	ANYTOWN	IL	62000	363106080-62000-01		11/01/15
	DBA:					TIN #: 01		

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
1112223338

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

Appendix A-12
Internet Quick Reference Guide

The Department's handbooks are designed for use via the Web and contain hyperlinks to the pertinent information.

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Claims Processing System Issues
Child Support Enforcement
Dental Program
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
Place of Service Codes
Centers for Medicare and Medicaid Services (CMS)

Appendix A-13

Anesthesia Payment Formula

General Anesthesia

Anesthesia units	+	(Modifying Units)	+	(Procedure Anesthesia Value)	X	(multiplier)
A	+	**B**	+	**C**	X	**D**

Epidural Anesthesia

Anesthesia units	X	75% (round down)	+	(Procedure Anesthesia Value)	X	(multiplier)
A	X	**(.75)**	+	**C**	X	**D**

A = Anesthesia units. Value is obtained by dividing the number of minutes by minutes per unit. Units are rounded up to the nearest whole number. For non-Medicare primary anesthesia claims, one unit = 12 minutes. For Medicare primary anesthesia claims, one unit = 15 minutes.

Medicare Crossovers
Electronic claims crossed over directly from Medicare to HFS indicate the quantity as the number of 15-minute units.

Electronic crossover claims submitted by the provider are to indicate the quantity modifier in Loop 2400 SV103 as “UN”, units, or “MJ”, minutes and SV104 as the corresponding number of 15-minute units or the number of minutes.

Paper claims crossed over by the provider are to show the quantity as the number of minutes.

HFS multiplies the unit quantity received by 15 minutes per unit to determine the number of minutes. Once the number of minutes is obtained, HFS divides by 12 minutes per unit and then the anesthesia payment formula is followed.

B = Physical status modifier. HFS-assigned value based on the use these CPT modifiers.

P1= 0 (old value A)
P2= 1 (old value B, E)
P3= 2 (old value C)
P4= 3 (old value D)
P5= 2 (old value F)
P6= 0 (old value G)

C = Anesthesia Value. HFS-assigned value, as shown on Practitioner Fee Schedule.

D = Current multiplier $15.35