TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION
FORM HFS 3797, 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.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the provider.
- 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, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- 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 in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid 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 photo-copying 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 claims. Do not fold invoices or fasten attachment with staples.
- **Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797.**

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.**

MediPlan Card – the identification card issued monthly by the Department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago) KidCare Assist or KidCare Moms and Babies, and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for Department consideration of Medicare coinsurance and deductibles.

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.

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 (previously billed on HCFA 1491) If provider type is not indicated above, enter a capital "X" in the Practitioner box.
Required	**1.**	**Recipient's Name** - Enter the recipient's name (first, middle, last) exactly as it appears on the back of the MediPlan card.
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.

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 from the MediPlan Card. 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 Excludes Transportation	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.
Required Excludes Transportation and Durable Medical Equipment	**10C.**	**T.O.S. (Type of Service)** – Refer to your specific Provider Handbook for instructions on billing TOS or Role.

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 provider 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 pharmacy/physician claims.
Conditionally Required Excludes Transportation	**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).
Required Transportation Only	**13A.**	**Origin of Service** – Enter the facility name or origin place address and city from which the patient was transported.
Required Transportation Only	**13B.**	**Modifier** – Enter the first alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).

Required Transportation Only	**14A.**	**Destination of Service** – Enter the facility name or destination place address and city from which the patient was transported.
Required Transportation Only	**14B.**	**Modifier** – Enter the second alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).
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-1, 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 recipient's treatments. A written description is not required if a valid ICD-9-CM code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the valid ICD-9-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 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".
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 Number exactly as it appears on the Provider Information Sheet. **Claims submitted May 23, 2008 and after, must contain 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 physician if the service or item was ordered or referred by a physician. Referring Physician – a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Physician – A physician who orders non-physician services for the Recipient 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 physician's order or referral must include the ordering/referring physician's Unique Physician/Practitioner Identification Number (UPIN).

Required	**27.**	**Medicare Provider ID Number** – Enter the carrier assigned Provider Identification Number (PIN) for the performing provider of service/supply.
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code.
Conditionally Required	**29A.**	**TPL Code** – The TPL Code contained on the Recipient's MediPlan Card is to be entered in this field. If payment was received from a third party resource not listed on the MediPlan Card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. If none of the TPL codes in the General Appendix 9 are applicable to the source of payment, 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.

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 on the MediPlan Card 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.

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. Unsigned claims will not be accepted by the Department and will be returned to the provider. 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
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 Web site at http://www.hfs.illinois.gov/forms/ or by submitting a 1517 or 1517A as explained in Chapter 100, General Appendix 10.