Providers of Podiatric Services Appendices

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Appendix F-1

Technical Guidelines for Paper Claim Preparation
Form HFS 1443, Provider Invoice

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

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

A sample of the HFS 1443(pdf), Provider Invoice, may be found on the Department's website.

Instructions for completion of the Provider Invoice 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 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.

Completion	Item	Explanation and Instructions
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** – Enter the provider's NPI.
Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**4.**	**Role** – Enter one of the following codes to define the relationship to the patient: 1- Attending podiatrist 2- Surgeon/Assistant Surgeon (enter appropriate modifier in Section 23) 3- Consultant
Not Required	5.	Emer – Leave Blank.
Conditionally Required	**6.**	**Prior Approval** – Enter the unique number from the computer generated prior approval notification, when billing a service for which approval has been obtained.

Completion	Item	Explanation and Instructions
Optional	**7.**	**Provider Street** – Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider errors. If address is not entered, the Department will not attempt corrections.
Conditionally Required	**8.**	**Facility & City Where Service Rendered** – This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office) or 12 (home).
Optional	**9.**	**Provider City State ZIP** – Enter city, state and ZIP code of provider.
Conditionally Required	**10.**	**Referring Practitioner Name** – Enter name of referring practitioner.
Required	**11.**	**Recipient Name** – Enter the patient's name. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required	**12.**	**Recipient No.** – Enter the nine-digit number assigned to the individual. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Optional	**13.**	**Birth Date** – Enter the month, day and year of birth of the patient. Use the MMDDYYYY format. If the birth date is entered, the Department will where possible, correct claims suspended due to recipient name or number errors. If the birth date is not entered, the Department will not attempt corrections.
Not Required	14.	H Kids – Leave Blank.
Not Required	15.	Fam Plan –Leave Blank.
Not Required	16.	St/Ab – Leave Blank
Required	**17.**	**Primary Diagnosis Description** – Enter the primary diagnosis that describes the condition primarily responsible for the patient's treatment.

Completion	Item	Explanation and Instructions
Required	**18.**	**Primary Diag. Code** – Enter the specific ICD-10 code without the decimal for the primary diagnosis described in Item 17.
Required	**19.**	**Taxonomy -** Enter the appropriate ten-digit HIPAA provider taxonomy code. Refer to Chapter 300.
Optional	**20.**	**Provider Reference** – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form 194-M-2, Remittance Advice, returned to the provider.
Conditionally Required	**21.**	**Ref Prac No.** – Enter NPI of referring practitioner.
Optional	**22.**	**Secondary Diag Code** – A secondary diagnosis code may be entered when applicable.
	23.	**Service Sections** – Complete one Service Section for each item or service provided to the patient.
Required		**Procedure Description/Drug Name, Form and Strength or Size** – Enter the description of the service provided or item dispensed.
Required		**Proc. Code/NDC** – Enter the appropriate CPT, HCPCS or NDC. Information regarding the reporting of an NDC is in Appendix F-5.
Conditionally Required		**Modifiers** – Enter the appropriate two-byte modifier (s) for the service performed. The Department can accept a maximum of 4 two-byte modifiers per Service Section.
Required		**Date of Service** – Enter the date the service was provided. Use MMDDYY format.
Required		**Cat. Serv.** – Enter the appropriate two-digit Category of Service code. 04 – Podiatric Services

Completion	Item	Explanation and Instructions
Conditionally Required	**23. (cont.)**	**Delete** – When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only the "X" will be recognized as a valid character; all others will be ignored.
Required		**Place of Serv.** – Enter the two-digit Place of Service code from the following list: 11 – Office 12 – Home 13 – Assisted Living Facility 14 – Group Home 21 – Inpatient Hospital 22 – Outpatient Hospital 31 – Skilled Nursing Facility 32 – Nursing Facility 33 – Custodial Care Facility
Conditionally Required		**Units/Quantity** – Enter the approved quantity from the computer generated prior approval notification, when applicable, otherwise enter "1".
Not Required		Modifying Units – Leave Blank.
Conditionally Required		**TPL Code** –The patient's TPL code is to be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the three-digit TPL code. If the patient has more than one third party resource, the additional TPL is to be shown in Section 25. **Do not report Medicare Information in the TPL fields.** Refer to Appendix F-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 EOMB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOMB.

Completion	Item	Explanations and Instructions
Conditionally Required	**23. (cont.)**	**Spenddown** – Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form HFS 2432 shows a participant liability greater than $0.00 the Service Section should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount The actual participant liability as shown on Form HFS 2432 TPL Date The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If Form HFS 2432 shows a participant liability of $0.00 the Service Section should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 0 00 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	**23. (cont.)**	**Status** – If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown** – TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 –TPL Adjudicated – patient not covered** – TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered** – TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – Spenddown met** – TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 – Patient Not Covered** – TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services Not Covered** – TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending** – TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 – Deductible Not Met** – TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Explanation and Instructions
Conditionally Required	**23. (cont.)**	**TPL Amount** – Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other Status Codes, enter 0 00. If there is no TPL code, no entry is required.
Conditionally Required		**TPL Date** – A TPL date is required when any status code is shown. Use the date specified below for the applicable code: **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
Required		**Provider Charge** – Enter the total charge for the service, not deducting any TPL or co-pays.
Not Required	24.	Optical Materials Only - Leave blank.
Sections 25 through 30 of the Provider Invoice are to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges. If an additional third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions.		
Conditionally Required	**25.**	**Sect. #** – If more than one third party made a payment for a particular service, enter the Service Section number (1 through 6) in which that service is reported. If a third party made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 25C will be applied to the total of all Service Sections on the Provider Invoice.

Completion	Item	Explanation and Instructions
Conditionally Required	**25A.**	**TPL Code** –Enter the appropriate TPL code referencing the source of payment. If the TPL Codes are not appropriate, enter Code 999 and enter the name of the payment source in Item 35.
Conditionally Required	**25B.**	**Status** – Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.
Conditionally Required	**25C.**	**TPL Amount** – Enter the amount of payment received from the third party resource.
Conditionally Required	**25D.**	**TPL Date** – Enter the date the claim was adjudicated by the third party resource. (See the TPL Date field in Item 23 above for correct coding of this field.)
Conditionally Required	**26.**	**Sect.** # – Enter (See 25 above).
Conditionally Required	**26A.**	**TPL Code** – (See 25A above.)
Conditionally Required	**26B.**	**Status** – (See 25B above).
Conditionally Required	**26C.**	**TPL Amount** – (See 25C above).
Conditionally Required	**26D.**	**TPL Date** – (See 25D above).
Conditionally Required	**27.**	**Sect.** – (See 25 above).
Conditionally Required	**27A.**	**TPL Code** – (See 25A above).
Conditionally Required	**27B.**	**Status** – (See 25B above).
Conditionally Required	**27C.**	**TPL Amount** – (See 25C above).

Completion	Item	Explanation and Instructions
Conditionally Required	**27D.**	**TPL Date** – (See 25D above).
Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.		
Required	**28.**	**Tot Charge** – Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
Required	**29.**	**Tot Deductions** – Enter the sum of all payments submitted in the TPL Amount field in the Service Sections 1 through 6. If no payment was received, enter zeroes (0 00).
Required	**30.**	**Net Charge** – Enter the difference between Total Charge and Total Deductions.
Required	**31.**	**# Sects** – Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections that were deleted because of errors.
Not Required	32.	Original DCN - Leave blank.
Not Required	33.	Sect - Leave blank.
Not Required	34.	Bill Type - Leave blank.
Conditionally Required	**35.**	**Uncoded TPL Name** – Enter the name of the third party resource. The name must be entered if TPL code 999 is used.
Required	**36-37**	**Provider Certification, Signature and Date** – After reading the certification statement, the provider or authorized biller must sign the completed form with the podiatrist's name followed by the biller's initials. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format.

Mailing Instructions

The HFS 1443 Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider.

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 EOBs or split bill transmittals (HFS 2432) are to be mailed to the Department in a pre-addressed mailing envelope, Form HFS 2248, NIPS Special Invoice Handling Envelope, which is provided by the Department for this purpose.

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

Forms Requisition - Billing forms may be requested on our website or by submitting a HFS 1517 as explained in Chapter 100.

Appendix F-2

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. The Department will not accept downloaded, created, reproduced or faxed forms.
- 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/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must 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 in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not 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 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.

A sample of the HFS 3797 (pdf), Medicare Crossover Invoice, may be found on the Department's website.

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form.**

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.

Completion	Item	Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the box labeled 23 – Practitioner (includes physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, and Imaging Centers).
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.**	**Was Condition Related to** – **A.** Recipient's Employment - Treatment for an injury or illness that resulted from participant's employment, enter a capital "X" in the "Yes" box. **B.** Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate. Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.
Required	**5.**	**Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number. Do not use the Case Identification Number.
Required	**6.**	**Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).
Required	**7.**	**Recipient's Relation to Insured** – Enter a capital "X" in the self 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 provider/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, 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. The "From" and "To" fields must be the same date.
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.

Completion	Item	Explanation and Instructions
Required	**10C.**	**T.O.S. (Type of Service)** – Enter the TOS code submitted to Medicare.
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. 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 podiatrist purchased and administered injectable medications.
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.

Completion	Item	Explanation and Instructions
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.
Not Required	15A.	Origin of Service – Leave blank.
Not Required	15B.	Modifier - Leave blank.
Not Required	16A.	Destination of Service - Leave blank.
Not Required	16B.	Modifier - Leave blank.
Optional	**17.**	**ICN #** - Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on Form HFS 194-M-2, Remittance Advice, returned to the provider.
Conditionally Required	**18.**	**Diagnosis or Nature of Injury or Illness** - Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-10 code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the specific ICD-10 code without the decimal for the primary diagnosis described in Item 18.
Optional	**18B.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter a specific ICD-10 code without the decimal for any applicable secondary diagnosis.
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.

Completion	Item	Explanation and Instructions
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 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 provider 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, and ZIP Code** – Enter the physician/supplier name exactly as it appears on the Provider Information Sheet in the "Provider Key".
Required	**23.**	**HFS Provider Number** – Enter the rendering 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** – 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 NPI number.
Not Required	27.	Medicare Provider ID Number - Leave blank.

Completion	Item	Explanation and Instructions
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Taxonomy for 837P.
Conditionally Required	**29A.**	**TPL Code** – TPL Code – The patient's TPL code is to be entered in this field. Please refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for the three-digit TPL code. If the TPL code is not known, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Field 30. Do not report Medicare information in the TPL fields. **Spenddown** – Refer to Chapter 100 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a 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	**29B.**	**TPL Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
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.

Completion	Item	Explanation and Instructions
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 website or by submitting a HFS 1517 as explained in Chapter 100.

Appendix F-3

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

Form HFS 1409 (pdf), Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Instructions for Completion

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

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

Required = Entry always required.

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

Not Required = Fields not applicable; leave blank.

Completion	Item	Explanation and Instructions
Required	**1.**	**Recipient ID Number** – Enter the nine-digit recipient number assigned to the patient for whom the service or item is requested.
Required	**2.**	**Recipient Name** – Enter the name of the patient for whom the service or item is requested.
Required	**3.**	**Birth date** – Enter the patient's birth date.
Required	**4.**	**Provider/NPI #** – Enter the provider 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.

Completion	Item	Explanation and Instructions
Required	**6.**	**Provider Name** – Enter the name of the provider who will provide the service or item.
Required	**7.**	**Physician Name** – Enter the name of the podiatrist or physician who signed the order or prescription recommending that the patient receive the specific item or service.
Required	**8.**	**Provider Street Address** – Enter the address of the 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 specific ICD-10 code without the decimal, for the primary diagnosis described in Item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis** –Enter the additional ICD-10 diagnosis code, if applicable.
Required	**14.**	**Diagnosis Description** – Enter the written description, which corresponds with the diagnosis code listed in Item 12.
Conditionally Required	**15.**	**Patient Height/Weight** – This field is required for durable medical equipment/supply requests.

Completion	Item	Explanation and Instructions
Required	**16.**	**Procedure Code** – Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested. For podiatry – if a quantity of two is requested (for instance, right and left), list the specific HCPCS code for the first, then 99199 for the second. **Description** – Briefly describe the services or items or materials to be provided. **Qty** – Enter the number of items to be dispensed in the time period covered by the prior approval request or enter the number of times the service is to be performed. **Cat. Serv** – Enter the two-digit category of service (COS) code corresponding to the related item/service. Valid entries are: 04 Podiatric Services **Prov Charge** – Enter the total amount to be charged for the item being requested. **Approved HFS Amt** – Leave Blank. **Begin Date** – If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval is granted, leave blank. **End Date** – Indicate the ending date of service, if applicable. **Pur/Rent** – Leave blank. **Mod** – Leave blank.
Conditionally Required	**17-20**	To be used for additional procedures. If more than five procedures are listed, another request must be made.
Required	**21.**	**Additional Medical Necessity** – To be used for other medical information.
Not Required	22.	Approving Authority Signature
Required	**23.**	**Provider Signature/Date** – To be signed in ink by the individual who is to provide the service.

Mailing Instructions

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

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

The signed copy of the request is to be mailed to:

Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Office Box 19124
Springfield, IL 62794-9124

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be billed until the approval notification is received.

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

Fax Instructions

The signed copy of the HFS 1409 may be faxed Monday through Friday, 8:30 AM – 5:00 PM, except holidays, to 217-524-0099.

Appendix F-4

Explanation of Information on Provider Information Sheet

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via IMPACT.

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 F-4a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI shown in field 8.
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 that 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 (cont)	**Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive Disregard the term NOCST if it appears in this item. Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in the 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 S = Exception Requested by Provider Participation Unit T = Tax Levy If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank. **AGR** (Agreement) indicates whether the provider has agreed to the Terms & Conditions in IMPACT. If the value of the field is yes, the provider is eligible to submit claims electronically.
Certification/ License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.
S.S. #	This is the provider's Social Security or FEIN number.

Field	Explanation
Categories of Service	**Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are: 004– Podiatric Services This entry is followed by the date that the provider was approved to render podiatric services.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to 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 provider database.
Signature	The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services.

Appendix F-4a
Reduced Facsimile of Provider Information Sheet

```
                                                STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS)                      HEALTHCARE AND FAMILY SERVICES                    RUN DATE: 02/02/16
PROVIDER SUBSYSTEM                                                                            RUN TIME: 11:47:06
REPORT ID:  A2741KD1                            PROVIDER INFORMATION SHEET                  MAINT DATE: 02/02/16
SEQUENCE:   PROVIDER TYPE                                                                        PAGE:    84
          PROVIDER NAME

- -PROVIDER KEY- -    PROVIDER NAME AND ADDRESS          PROVIDER TYPE:        013 – PODIATRIST
                     GOODNIGHT E.J.                     ORGANIZATION TYPE:     01 – INDIVIDUAL PRACT
    016012345        1421 MY STREET                     ENROLLMENT STATUS       B – ACTIV NOCST     BEGIN 01/15/02 END ACTIVE
                     ANYTOWN, IL  62000                 EXCEPTION INDICATOR       - NO EXCEPT       BEGIN          END
                                                                                                     AGR: YES  BILL: NONE
                     PROVIDER GENDER:
                     COUNTY 089-SCOTT                          CERTIFIC/LICENSE NUM – 016012345  ENDING 03/31/17
                     TELEPHONE NUMBER (217)742-1234                                                        UPIN#:
                                                               LAST TRANSACTION ADD              AS OF 05/21/12   SS  #: 331313131
                     D.E.A.#:                                                                                   CLIA#:
                     RE-ENROLLMENT INDICATOR:  N   DATE: 11/15/15
HEALTHY KIDS/HEALTHY MOMS INFORMATION:  BEGIN DATE  /  /

                                                                                                                 SPECIALTY
                                                ELIG
 COS    ELIGIBILITY CATEGORY OF SERVICE         BEG DATE     COS    ELIGIBLITY CATEGORY OF SERVICE    BEG DATE

 004    PODIATRY SERVICES                       01/15/02

 PAYEE
 CODE       PAYEE NAME              PAYEE STREET          PAYEE CITY        ST  ZIP    PAYEE ID NUMBER    DMERC#     EFF DATE
  1         E.J. GOODNIGHT          1421 MY STREET        ANYTOWN           IL  62000  016012345-62000-01            01/15/02
            DBA:                                                            VENDOR ID: 01
            MEDICARE/PIN: 355730/L12345

    *** NPI NUMBERS REGISTERED FOR THIS PROVIDER ARE:
        XXXXXXXXX

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

Appendix F-5

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, Topic 302.

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 1443.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 of 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 podiatry 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.

- Claim may be submitted electronically or on paper.
- Enter the name of the drug, strength of the drug, and the amount given in the description or note field/NTE segment.

These procedure codes are identified on the Podiatric 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 23 on the paper HFS 1443 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 F-6
Telehealth Billing Examples

Billing Examples for Telemedicine Services

Example 1: Originating Site – Physician's office
Bill HCPCS Code Q3014
Reimbursement is $25.00

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
Reimbursement is $25.00

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 3: 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 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 – Podiatrist's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider

Appendix F-7

Place of Service Codes

The following identifies the most commonly used Place of Service Codes for podiatrist billing.

Code	Name	Description
03	School	A facility whose primary purpose is education.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where participants receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
19	Off-Campus Outpatient Hospital	A portion of an off-campus hospital provider based department that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016).
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On-Campus Outpatient Hospital	A portion of a hospital's main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Code	Name	Description
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service Code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

Code	Name	Description
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location, which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician’s office.
99	Other Place of Service	Other place of service not identified above.

Appendix F-8

Type of Service Codes

The following are the Type of Service (TOS) Codes acceptable by the Department. These apply only to paper claims.

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
7 Anesthesia – Anesthesiologist, CRNA
8 Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon

Appendix F-9

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 F-10

Internet Quick Reference Guide

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

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Centers for Medicare and Medicaid Services (CMS)
Child Support Enforcement
Claims Processing System Issues
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)
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Place of Service Codes
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
State Chronic Renal Disease Program