

## PROVIDER MANUAL SUPPLEMENT

### THIRD-PARTY LIABILITY

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## THIRD-PARTY LIABILITY SUPPLEMENT

### INTRODUCTION

“Third-party liability” (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers’ compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

### HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid’s TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary’s eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

### ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient’s responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance.** You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid’s third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid



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patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Medicaid does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Medicaid all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

### Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

### Eligibility Verification

- **Medicaid Card:** Possession of a Medicaid card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **IVRS:** Instructions for using the Interactive Voice Response System (IVRS) are included in Section 1 of your provider manual. Information about third-party insurers comes after basic eligibility information, so be sure to listen all the way through the response message.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Medicaid Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

### REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.



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### Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in the Forms section of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

Medicaid Insurance Verification Services  
PO Box 101110  
Columbia, SC 29211-9804  
Fax: (803) 252-0870

### COORDINATION OF BENEFITS

Health insurers adhere to “coordination of benefits” provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the “primary” payer, the next is termed “secondary,” and the third is called “tertiary.” Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

### COST AVOIDANCE VS. PAY & CHASE

South Carolina Medicaid is required by the federal government to reject claims for which another party might be liable; this policy is known as “cost avoidance.” Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as “Pay & Chase.” Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in



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this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

### Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children's Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

### COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

**Remember, as a Medicaid provider you have agreed to accept Medicaid's payment as payment in full.** You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect



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the Medicaid beneficiary by limiting his or her liability for payment for medical services. Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

### DENIALS AND EOBs

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

### POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

**The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy.** The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call your SCDHHS program representative. He or she can look up more details of the plan in the TPL policy file.

### TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must resubmit the Edit Correction Form (ECF) within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.



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Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

### REASONABLE EFFORT

Providers occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. It is your responsibility as a provider to seek a solution to such problems.

“Reasonable effort” consists of taking logical, timely steps at each stage of the billing process. Such steps may include resubmitting claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. Your program representative can work with you to explore these options.

### Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

**A. Send a claim to the insurance company.**

If after **thirty days** you have received no response:

**B. Call the company's customer service department to determine the status of the claim.**

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.
  2. Confirm that all requested information has been submitted.



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3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.
  - **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
    1. Make a note in your files.
    2. Follow up with a written request for a response.

**C. If after two more weeks you have still received no response:**

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

### Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

### Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

Attach the form either to a claim filed as a denial or to an ECF. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance,



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notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in the Forms section of your provider manual, and examples appear at the end of this supplement.

### REPORTING TPL INFORMATION ON CLAIMS

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

### Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix DN (dental plans) or RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. The five-digit carrier codes for pharmacy claims submission may be found at <http://southcarolina.fhsc.com> or [www.scdhhs.gov](http://www.scdhhs.gov).

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, check the carrier code list on the SCDHHS Web site (From [www.scdhhs.gov](http://www.scdhhs.gov) click Resource Library, then Forms, and scroll to the bottom). If an ECF lists a code that you cannot find among the carrier codes either in your manual or online, contact your program area for assistance.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.



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You may encounter the “CAS” carrier code when checking a beneficiary’s eligibility. This code represents an open casualty case. Medicaid does not cost avoid claims with casualty coverage. You may decide to bill Medicaid directly and forgo participation in the case, or you may take action with the liable party and not bill Medicaid. Timely filing requirements still apply even where there is a possible casualty settlement, so you must make your decision prior to the one-year Medicaid timely filing deadline.

### Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary’s health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary’s SSN. Edit codes and rejected claims are discussed in more detail below.

### PHARMACY CLAIMS

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists’ billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Medicaid maintains separate carrier codes for pharmacy claims submission. The list of pharmacy carrier codes is available on the SCDHHS Web site (From [www.scdhhs.gov](http://www.scdhhs.gov) click Providers, then Pharmacy, then Carrier Code Lists). These unique codes may also be found at <http://southcarolina.fhsc.com>.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Medicaid edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor’s Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

### NURSING FACILITY CLAIMS

Nursing facilities are required to follow Medicaid’s TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or send the insurance EOB with an ECF.



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If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

To initiate Medicaid billing for a resident also covered by a third party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive an ECF for the claim, attach all EOBs and return the ECF to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. Your Nursing Facility program representatives will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call your Nursing Facility program representative. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

### PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500, UB-04, and ADA claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you may write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the ECF, and submit the ECF to MCCS. Claims submitted electronically will be processed automatically with up to ten primary payers. You may also submit the ECF and all the EOBs to



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the Division of Third-Party Liability; however, that is no longer required and may slightly delay claim payment.

### Professional Paper Claims

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

### CMS-1500 TPL Fields

<b>9a Other Insured's Policy or Group Number</b> Enter the policy number.	<b>11 Insured's Policy Group or FECA Number</b> Enter the policy number.
<b>9c Employer's Name or School Name</b> If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	<b>11b Employer's Name or School Name</b> If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
<b>9d Insurance Plan Name or Program Name</b> Enter the three-digit carrier code.	<b>11c Insurance Plan Name or Program Name</b> Enter the three-digit carrier code.

#### 10d Reserved for Local Use

Enter the appropriate TPL indicator for this claim.

The valid TPL indicators are:

- 1** Insurance denied
- 6** Crime victim
- 8** Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator "1" in field 10d. "6" is used to alert SCDHHS to potential criminal proceedings and restitution. "8" is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

#### 29 Amount Paid

Enter the total amount paid from all insurance sources.  
This amount is the sum of 9c and 11b.

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.



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### Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. If you are using a Medicaid legacy provider number, it must appear on the same line as the Medicaid carrier code. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

### UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		\$33.01
B	401 (BCBS carrier code)		\$255.39
C	619 (Medicaid carrier code)	123456	

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.



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### Dental Paper Claims

The 2006 ADA claim form provides space for entering up to two insurers other than Medicaid.

### ADA Claim TPL Fields

<b>4</b> <b>Other Dental or Medical Coverage?</b> Mark “Yes” or “No.”	<b>12</b> <b>Name, Address, City, Etc.</b> If private insurance company or Medicare denial is listed on the claim with a zero payment, write 0.00 and put the number “1” in this field. If you have received a payment, put the amount paid to you in this field.
<b>8</b> <b>Policyholder/Subscriber Identifier</b> Enter the private insurance or Medicare policy number if you have billed either one.	<b>15</b> <b>Policyholder/Subscriber Identifier</b> Enter the private insurance or Medicare policy number if you have billed either one.
<b>9</b> <b>Plan/Group Number</b> Enter the three-digit carrier code of the private insurance company or Medicare.	<b>16</b> <b>Plan/Group Number</b> Enter the three-digit carrier code of the private insurance company or Medicare.
<b>11</b> <b>Other Insurance/Benefit Plan Name Etc.</b> If private insurance company or Medicare denial is listed on the claim with a zero payment, write 0.00 and put the number “1” in this field. If you have received a payment, put the amount paid to you in this field.	

### 35 Remarks

Enter the total amount received from other insurance sources (sum of fields 11 and 12). If the private insurance or Medicare denies payment, put in \$0.00.

The Dental Services provider manual contains sample claims and complete instructions for filling out dental claim forms, and a sample ADA claim form appears at the end of this supplement.

### Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types using the Web Tool. The basic steps are the same as for paper claims.



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### REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Edit Correction Form will supply information you need to file with the third-party payer.

### Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed on the ECF, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information.

TPL information appears on the ECF to the right of the Medicaid claims receipt address under the heading “INSURANCE POLICY INFORMATION.” The insurance carrier code, the policy number, and the name of the policyholder are all listed on the ECF, while the carrier’s address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site.

Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the ECF, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the claim to what appears on the ECF. Enter the correct information on the ECF.

You can also refile a claim instead of returning an ECF. If you choose to refile a claim that was rejected for any reason, you must re-enter all TPL information.

Other TPL-related edit codes include:

- 316:** Third party code invalid
- 317:** Invalid injury code
- 390:** TPL payment amount not numeric
- 400:** TPL carrier and policy number must both be present
- 401:** Amount in other sources, but no TPL carrier code



## THIRD-PARTY LIABILITY SUPPLEMENT

- 555:** TPL payment is greater than payment due from Medicaid
- 557:** Carrier payments must equal payments from other sources
- 565:** Third-party payment, but no third-party ID
- 690:** Amount from other sources more than Medicaid amount
- 732:** Payer ID number not on file
- 733:** Insurance information coded, but payment or denial indicator missing
- 953:** Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual. Sample corrected ECFs appear at the end of this supplement.

### CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see the Forms section of your provider manual) and send it with the check to the following address:

SCDHHS  
Cash Receipts  
PO Box 8355  
Columbia, SC 29202

### RECOVERY

“Recovery” refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.



## THIRD-PARTY LIABILITY SUPPLEMENT

### Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each quarter for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited approximately six weeks later. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an “own reference number” to identify the debit(s).

You are expected to file the affected claims to Medicare within the quarter of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 509 for being more than two years after the date of service or six months after the Medicare remittance date, mail or fax the ECF to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the ECF should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

The computer logic that selects the dates of service for claims pulled into Retro Medicare is based upon the CMS guidelines for Part B timely filing, which are as follows:

A Medicare Part B claim must be filed no later than the end of the calendar year following the year in which the service was furnished, with one exception: the time limit on filing claims for service furnished in the last three months of a year is the same as if the services had been furnished in the subsequent year. Thus, the time limit on filing claims for services furnished in the last three months of the year is December 31 of the second year following the year in which the services were rendered. This is best illustrated by the following table.

***Medicare Part B Timely Filing***

<b>Date of Service in:</b>	<b>Timely Filing Date</b>	<b>Months to File*</b>
Jan	Dec 31: Service year plus 1 year	23
Feb	Dec 31: Service year plus 1 year	22
Mar	Dec 31: Service year plus 1 year	21
Apr	Dec 31: Service year plus 1 year	20
May	Dec 31: Service year plus 1 year	19
June	Dec 31: Service year plus 1 year	18
July	Dec 31: Service year plus 1 year	17
Aug	Dec 31: Service year plus 1 year	16
Sep	Dec 31: Service year plus 1 year	15



## THIRD-PARTY LIABILITY SUPPLEMENT

Oct	Dec 31: Service year plus 2 years	26
Nov	Dec 31: Service year plus 2 years	25
Dec	Dec 31: Service year plus 2 years	24

\* The number of full months remaining after the month in which the service was rendered

South Carolina Medicaid is responsible for attempting to recover all claims that can be filed within timely filing limits. As a result, and because of the Medicare Part B timely filing schedule, “old” claims may be pulled into recovery because the provider is still able to file them to Medicare.

Please note that the computer logic also reviews the procedures on the claims and does not pull into recovery procedure codes that are not Medicare covered.

### Retro Health and Pay & Chase

SCDHHS invoices institutional providers each quarter for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the quarter of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

Approximately four months after the recovery letter, providers are notified of any claims for which there has been no response. Again, six months after the initial invoice, providers are notified of non-response. At the end of nine months from the initial invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the one-year cycle.

#### Retro Health Example

January 2005	Initial invoice
May 2005	Second letter
July 2005	Third letter
September 2005	Notification: Automated debit on last check date of the month
December 2005	Deadline for reconsideration

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier’s deadline, this is not an acceptable denial; however, when an insurer’s timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer’s denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary



## THIRD-PARTY LIABILITY SUPPLEMENT

payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

### CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims and ECFs.



## THIRD-PARTY LIABILITY SUPPLEMENT

### TPL RESOURCES

Your SCDHHS program representative is your first source for questions about third-party liability. Listed below are some other resources:

**SCDHHS Web site:** [www.scdhhs.gov](http://www.scdhhs.gov)

- Carrier codes
- Provider manuals
- Edit codes and resolutions

**Provider Outreach Web site:** [www.scmecaidprovider.org](http://www.scmecaidprovider.org)

- Web Tool User Guide and Addenda

#### **Medicaid Insurance Verification Services**

PO Box 101110  
Columbia, SC 29211-9804  
(803) 252-7070 Main Number  
(803) 933-1752 Provider Recovery Specialists  
(803) 933-1825 Health Insurance Premium Payment Project  
(803) 252-0870 Fax

#### **South Carolina Department of Insurance**

300 Arbor Lake Drive, Suite 1200  
PO Box 100105  
Columbia, SC 29223  
[www.doi.state.sc.us](http://www.doi.state.sc.us)

#### **SCDHHS Division of Third-Party Liability**

(803) 898-2630

#### **SCDHHS Casualty Department**

(803) 898-2977

#### **SCDHHS Health Insurance Department**

(803) 898-2907

#### **SCDHHS Estate Recovery Department**

PO Box 100127  
Columbia, SC 29202  
(803) 898-2932

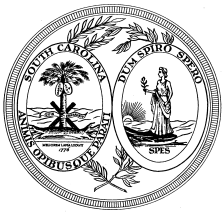


## THIRD-PARTY LIABILITY SUPPLEMENT

### SAMPLE FORMS

Form	Page
Health Insurance Information Referral Form: Carrier change	21
Health Insurance Information Referral Form: Coverage ended	22
Reasonable Effort Documentation Form: Failure to respond – beneficiary	23
Reasonable Effort Documentation Form: Failure to respond – insurer	24
Reasonable Effort Flowchart	25
Adjustment Form 130: Won appeal to primary	26
Adjustment Form 130: Retroactive private coverage and subsequent private payment	27
UB-04: Medicare paid; private insurer denied	28
Dental: Two private insurers paid	29
CMS-1500: Two private insurers; one paid, one denied	30
CMS-1500: Medicare and private insurer paid	31
ECF: Correction to add carrier payment	32
ECF: Correction to add carrier denial and note about policy lapse	33





**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/08

**I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS**

Beneficiary Name: John Doe Date Referral Completed: 02/28/08

Medicaid ID#: 9999999999 Policy Number: DH123456

Insurance Company Name: National Dental Insurance Group Number: QWE1234

Insured's Name: Jane Doe Insured SSN: 123-45-6789

Employer's Name/Address: South Carolina State Library, 1500 Senate Street, Columbia, SC, 29201

**II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS**

☐ a. beneficiary has never been covered by the policy – close insurance.

☐ b. beneficiary coverage ended - terminate coverage (date) \_\_\_\_\_

☐ c. subscriber coverage lapsed - terminate coverage (date) \_\_\_\_\_

☒ d. subscriber changed plans under employer - new carrier is GloboChem  
- new policy number is A1111111110

☐ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) \_\_\_\_\_

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Submit this information to Medicaid Insurance Verification Services (MIVS).

**Fax:** 803-252-0870 **or** **Mail:** Post Office Box 101110  
Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN**

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

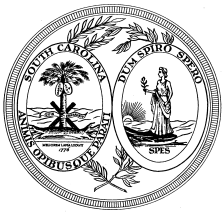
Medicaid Beneficiary ID: \_\_\_\_\_ SSN: \_\_\_\_\_

Carrier Name/Code: \_\_\_\_\_ New Unique Policy Number: \_\_\_\_\_

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

**Fax:** 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL  
Columbia, SC 29202-8206





**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: ABC Family Practice Provider ID or NPI: 8888888888

Contact Person: Betty Medicine, MD Phone #: 803-555-1111 Date: 03/01/08

**I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS**

Beneficiary Name: Jim Smith Date Referral Completed: 02/29/08

Medicaid ID#: 2222222222 Policy Number: AZ99999999999

Insurance Company Name: OmniCorp Insurers Group Number: 390-OP-777777

Insured's Name: N/A Insured SSN: 777-77-0000

Employer's Name/Address: Retired

**II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS**

☐ a. beneficiary has never been covered by the policy – close insurance.

☒ b. beneficiary coverage ended - terminate coverage (date) 12-31-2007

☐ c. subscriber coverage lapsed - terminate coverage (date) \_\_\_\_\_

☐ d. subscriber changed plans under employer - new carrier is \_\_\_\_\_

- new policy number is \_\_\_\_\_

☐ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) \_\_\_\_\_

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Submit this information to Medicaid Insurance Verification Services (MIVS).

**Fax:** 803-252-0870 **or** **Mail:** Post Office Box 101110  
Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN**

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: \_\_\_\_\_ SSN: \_\_\_\_\_

Carrier Name/Code: \_\_\_\_\_ New Unique Policy Number: \_\_\_\_\_

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

**Fax:** 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL  
Columbia, SC 29202-8206





**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** Acme Orthopedic **DOS** 01/01/07

**NPI or MEDICAID PROVIDER ID** 1234567890

**MEDICAID BENEFICIARY NAME** Jane Doe

**MEDICAID BENEFICIARY ID#** 1111111111

**INSURANCE COMPANY NAME** Jones Health Insurance

**POLICYHOLDER** Jane Doe

**POLICY NUMBER** 987654321J

**ORIGINAL DATE FILED TO INSURANCE COMPANY** 01/15/07

**DATE OF FOLLOW UP ACTIVITY** 02/16/07

**RESULT:**

Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

**FURTHER ACTION TAKEN:**

Called beneficiary on 02/16/07, 02/18/07, and 02/28/07. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

**DATE OF SECOND FOLLOW UP** 03/05/07

**RESULT:**

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/05; they will not act without forms.

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.**

Mary Orthoped 03/12/07  
(SIGNATURE AND DATE)

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**





**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** Dr. Betty Smith **DOS** 03/05/07

**NPI or MEDICAID PROVIDER ID** 1231231230

**MEDICAID BENEFICIARY NAME** John Jones

**MEDICAID BENEFICIARY ID#** 9999999999

**INSURANCE COMPANY NAME** Global Health

**POLICYHOLDER** John Jones

**POLICY NUMBER** 8888888888

**ORIGINAL DATE FILED TO INSURANCE COMPANY** 03/07/07

**DATE OF FOLLOW UP ACTIVITY** 04/06/07

**RESULT:**

Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/07.

**FURTHER ACTION TAKEN:**

04/27/07: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/07.

**DATE OF SECOND FOLLOW UP** 05/30/07

**RESULT:**

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/07. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.**

Betty Smith 06/03/07

**(SIGNATURE AND DATE)**

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**



# How to Obtain a Response from an Insurance Company

## A Suggested Third-Party Filing Process

Send a claim to the insurance company within 30 days of the service.

Allow  
**30 days**  
for a reply.

If you have received no response, call the company's customer service department to determine the status of the claim.

**The company has not received the claim.**

Re-file the claim. Stamp the claim as a repeat submission or send a cover note.

**The company has received the claim, considers the billing valid, and has not suspended the claim**

Make a note in your files and follow up with a written request for a response.

Allow  
**two more weeks.**

**The company has received the claim but considers the billing insufficient.**

Supply all additional information requested by the company.

Confirm with the company that all requested information has been submitted.

### Remember:

- Keep detailed records.
- Call your DHHS program representative if you need help.

If you have received no reply, write to the company citing this history of difficulties. Copy the SC Department of Insurance Consumer Division on your letter.



# South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

**Johnson DME Supply**

Provider Address :

**111 Oak Lane**

Provider City , State, Zip:

**Anywhere, SC 22222-2222**

Total paid amount on the original claim:

**\$1244.00**

Original CCN:

5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID:

A B C 1 2 3

NPI:

1 2 3 4 5 6 7 8 9 0

Recipient ID:

2 2 2 2 2 2 2 2 2 2

Adjustment Type:

☐ Void ☒ Void/Replace

Originator:

☐ DHHS ☐ MCCS ☒ Provider ☐ MIVS

Reason For Adjustment: (Fill One Only )

- ☒ Insurance payment different than original claim
- ☐ Keying errors
- ☐ Incorrect recipient billed
- ☐ Voluntary provider refund due to health insurance
- ☐ Voluntary provider refund due to casualty
- ☐ Voluntary provider refund due to Medicare
- ☐ Medicaid paid twice - void only
- ☐ Incorrect provider paid
- ☐ Incorrect dates of service paid
- ☐ Provider filing error
- ☐ Medicare adjusted the claim
- ☐ Other

For Agency Use Only

Analyst ID:

- ☐ Hospital/Office Visit included in Surgical Package
- ☐ Independent lab should be paid for service
- ☐ Assistant surgeon paid as primary surgeon
- ☐ Multiple surgery claims submitted for the same DOS
- ☐ MMIS claims processing error
- ☐ Rate change
- ☐ Web Tool error
- ☐ Reference File error
- ☐ MCCS processing error
- ☐ Claim review by Appeals

Comments:

Insurer denied claim -- decided equipment wasn't medically necessary.  
We filed to Medicaid, but then appealed to primary insurer. We won the appeal.

Signature: **Jane Doe**

Date: **04/01/07**

Phone: **(555) 555-5555**



# South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

**Dr. Joe Jones**

Provider Address :

**123 Main Street**

Provider City , State, Zip:

**Somewhere, SC 22222-0000**

Total paid amount on the original claim:

**\$230**

Original CCN:

**8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A**

Provider ID:

NPI:

**9 8 7 6 5 4 3 2 1 0**

Recipient ID:

**7 7 7 7 7 7 7 7 7 7**

Adjustment Type:

☐ Void ☒ Void/Replace

Originator:

☐ DHHS ☐ MCCS ☒ Provider ☐ MIVS

Reason For Adjustment: (Fill One Only )

- ☐ Insurance payment different than original claim
- ☐ Keying errors
- ☐ Incorrect recipient billed
- ☒ Voluntary provider refund due to health insurance
- ☐ Voluntary provider refund due to casualty
- ☐ Voluntary provider refund due to Medicare
- ☐ Medicoid paid twice - void only
- ☐ Incorrect provider paid
- ☐ Incorrect dates of service paid
- ☐ Provider filing error
- ☐ Medicare adjusted the claim
- ☐ Other

For Agency Use Only

Analyst ID:

- ☐ Hospital/Office Visit included in Surgical Package
- ☐ Independent lab should be paid for service
- ☐ Assistant surgeon paid as primary surgeon
- ☐ Multiple surgery claims submitted for the same DOS
- ☐ MMIS claims processing error
- ☐ Rate change
- ☐ Web Tool error
- ☐ Reference File error
- ☐ MCCS processing error
- ☐ Claim review by Appeals

Comments:

**Beneficiary just learned that her new private insurance is retroactively effective. We filed with and were paid by the insurer.**

Signature: **Mary Smith**

Date: **06/03/07**

Phone: **(803) 555-5555**



UB-04 CMS-1450      APPROVED OMB NO. 0938-0997       **NUBC**<sup>®</sup> National Uniform Billing Committee      THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF



# ADA Dental Claim Form

## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- ☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization  
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

## OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5  
☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employer Name

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned by Dentist)

## RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

## MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J			
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee		

35. Remarks

## AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X \_\_\_\_\_  
 Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X \_\_\_\_\_  
 Subscriber signature Date

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number ( ) - 52A. Additional Provider ID

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other 39. Number of Enclosures (00 to 99)  
 Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X \_\_\_\_\_  
 Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number ( ) - 58. Additional Provider ID



1500

One Carrier Paid; One Carrier Denied

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input checked="" type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John A.</b>										3. PATIENT'S BIRTH DATE MM DD YY SEX <b>01 01 1947 M <input checked="" type="checkbox"/> F <input type="checkbox"/></b>									
5. PATIENT'S ADDRESS (No., Street) <b>123 Windy Lane</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY <b>Anytown</b> STATE <b>SC</b>										7. INSURED'S ADDRESS (No., Street)  CITY  STATE  ZIP CODE <b>29999</b> TELEPHONE (Include Area Code) <b>( )</b>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>A11111111122</b>										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX  c. EMPLOYER'S NAME OR SCHOOL NAME <b>0.00</b>										11. INSURED'S POLICY GROUP OR FECA NUMBER <b>012345678</b> a. INSURED'S DATE OF BIRTH MM DD YY SEX  b. EMPLOYER'S NAME OR SCHOOL NAME <b>10.00</b> c. INSURANCE PLAN NAME OR PROGRAM NAME <b>400</b>									
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>134</b>										10d. RESERVED FOR LOCAL USE <b>1</b> d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <b>Signature on File</b> DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED									
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
19. RESERVED FOR LOCAL USE										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>295 32</b> 3. 2. 4. 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1										ZZ 1212121212 NPI 1234567890									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>55555555</b> <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. <b>DOE1234</b>									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <b>20.00</b> 29. AMOUNT PAID \$ <b>10.00</b> 30. BALANCE DUE \$ <b>10.00</b>									
32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b.										33. BILLING PROVIDER INFO & PH # <b>(555) 5555555</b> <b>ABC Clinic</b> <b>111 Main Street</b> <b>Anytown, SC 22222-2222</b> a. <b>1234567890</b> b. <b>ZZ1212121212</b>									

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



1500

Medicare Paid; Private Carrier Paid

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input checked="" type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John A.</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1947</b> SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) <b>123 Windy Lane</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY <b>Anytown</b> STATE <b>SC</b>										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY STATE																																							
ZIP CODE <b>29999</b> TELEPHONE (Include Area Code) <b>( )</b>										Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										ZIP CODE TELEPHONE (Include Area Code) <b>( )</b>																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER <b>111222333A</b>																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>012345678</b>										a. INSURED'S DATE OF BIRTH MM DD YY <b>10.00</b> SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME <b>10.00</b>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY <b>5.00</b> M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME <b>5.00</b>										c. INSURANCE PLAN NAME OR PROGRAM NAME <b>620</b>																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME <b>400</b>										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <b>Signature on File</b> DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																																																	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <b>NPI</b> 17b. <b>NPI</b>										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																							
19. RESERVED FOR LOCAL USE										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>295 32</b> 2. <b>32</b> 3. <b>32</b> 4. <b>32</b>										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																							
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																											
1 01 31 07 01 31 07 11 99999 20.00 1 ZZ 1212121212																				NPI 1234567890																																							
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25. FEDERAL TAX I.D. NUMBER SSN EIN <b>55555555</b> <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. <b>DOE1234</b>										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>20.00</b>										29. AMOUNT PAID \$ <b>15.00</b>										30. BALANCE DUE \$ <b>5.00</b>									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b.										33. BILLING PROVIDER INFO & PH # <b>(555) 5555555</b> <b>ABC Clinic</b> <b>111 Main Street</b> <b>Anytown, SC 22222-2222</b> a. <b>1234567890</b> b. <b>ZZ1212121212</b>																																							

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



RUN DATE 06/01/2007 000001204

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2  
PROVIDER RECIPIENT  
ID ID

SFL ZIP:

3 4 5 6  
P AUTH TPL INJURY  
NUMBER CODE

PRV ZIP:

7 8  
PC COORD  
EMERG

9  
---- DIAGNOSIS ----  
PRIMARY SECONDARY

ABC123 111111111  
NPI: 1234567890

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 60 PRAC SPEC - 12

DOC IND N

CLAIM CONTROL #9999999999999999A

PAGE 1136 ECF 1136 PAGE 1 OF 1

EMC Y

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

00-150

CLAIM EDITS

LINE EDITS

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18  
RES ALLOWED LN DATE OF PLACE PROC MOD  
NO SERVICE CODE

23  
NDC

19 20 21 22  
INDIVIDUAL CHARGE PAY UNITS  
PROVIDER IND

\*\*\*\*\*  
\*\* AGENCY USE ONLY \*\*  
\*\* APPROVED EDITS \*\*  
\*\* REJECTED LINE EDITS \*\*  
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.00 1 05/07/07 11 85025 000 ABC123 29.50 1.000  
NPI: 1234567890 TAXONOMY: 1212121212  
2 / /  
NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!  
! CLAIMS/LINE PAYMENT INFO !  
! !  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26  
INS CARR POLICY INS CARR  
NUMBER NUMBER PAID

27 TOTAL CHARGE 29.50

01 401 1231231230 5.00  
02  
03

28 AMT REC'D INS .00 5.00  
29 BALANCE DUE 29.50 24.50  
30 OWN REF # DOE12345

RESOLUTION DECISION \_R\_

ADDITIONAL DIAG CODES: . . . . .

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

401 1231231230  
DOE JOHN

PROVIDER:  
ABC HEALTH PROVIDER  
PO BOX 00000  
ANYWHERE, SC 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"  
\* INDICATES A SPLIT CLAIM



RUN DATE 06/01/2007 000001204

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2  
PROVIDER RECIPIENT  
ID ID

SFL ZIP:

3 4  
P AUTH TPL  
NUMBER

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 60 PRAC SPEC - 12

DOC IND N

PRV ZIP:

5 6 7  
INJURY EMERG PC COORD  
CODE

8 9  
---- DIAGNOSIS ----  
PRIMARY SECONDARY

CLAIM CONTROL #9999999999999999A

PAGE 1136 ECF 1136 PAGE 1 OF 1

EMC Y

ORIGINAL CCN:

ADJ CCN:

EDITS

INSURANCE EDITS

00-150

CLAIM EDITS

LINE EDITS

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18  
RES ALLOWED LN DATE OF PLACE PROC MOD  
NO SERVICE CODE

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NDC

19 20 21 22  
INDIVIDUAL CHARGE PAY UNITS  
PROVIDER IND

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\*\* AGENCY USE ONLY \*\*  
\*\* APPROVED EDITS \*\*  
\*\* REJECTED LINE EDITS \*\*  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:  
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NPI: TAXONOMY:

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! CLAIMS/LINE PAYMENT INFO !  
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! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!

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INS CARR POLICY INS CARR  
NUMBER NUMBER PAID

27 TOTAL CHARGE 29.50

01 401 9999999999 0.00  
02  
03

28 AMT REC'D INS .00  
29 BALANCE DUE 29.50  
30 OWN REF # DOE12345

RESOLUTION DECISION \_R\_

ADDITIONAL DIAG CODES: . . . . .

RETURN TO:  
MEDICAID CLAIMS RECEIPT  
P. O. BOX 1412  
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

401 9999999999  
DOE JOHN

PROVIDER:  
ABC HEALTH PROVIDER  
PO BOX 00000  
ANYWHERE, SC 00000-0000

(No longer covered by this insurance.)

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

\* INDICATES A SPLIT CLAIM