MIAMI CHILDREN'S HEALTH PLAN
Florida's Family Health Plan

MEDICAL FOSTER CARE CLAIMS FILING GUIDE

General Information

The following instructions explain how to complete the CMS 1500 claim form. These instructions are only applicable to paper CMS 1500 claim forms and do not apply to electronic claims, commonly known as 837 transactions. For information about electronic claims, please refer to the 837P Companion Guide located on the Agency for Health Care Administration's (AHCA) website, at http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx or contact Miami Children's Health Plan's (MCHP) Clearinghouse, Change Healthcare at (800) 845-6592.

MCHP's preferred method of claim submission is HIPAA-compliant 837 transactions, but paper claims are acceptable and processed within the required timeframes defined by the Agency for Health Care Administration.

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, and medical foster care services.

Current CPT and HCPCS procedure codes are required to identify the services provided. Medical Foster Care services are billed using the HCPCS codes and modifiers listed below, unless otherwise stated in your MCHP Provider Agreement.

HCPCS CODE	MODIFIER	DESCRIPTION
S5145	HA	Level I Medical Foster Care
S5145	TF	Level II Medical Foster Care
S5145	TG	Level III Medical Foster Care

Current ICD-10 codes are required to identify the diagnosis associated with the services provided. MCHP's Provider Relations Department can assist you in locating the correct ICD-10 code if necessary.

Paper claims must be legible in order to be processed for payment. Claim forms that contain any of the following will be rejected:

- Highlighter or color marks
- Copy overexposure marks
- Correction fluid or correction tape
- Labels or stickers
- Handwritten entries other than the provider signature in box 31

MCHP requires that its contracted providers have a National Provider Identifier (NPI). Medical Foster Care providers who do not have an NPI may obtain one by accessing the following website https://nppes.cms.hhs.gov/#/

- Select create new account
- Enter information in applicable fields
- A confirmation email will be sent to requester

For assistance requesting an NPI, please contact MCHP's Provider Relations Department at (844) 243-5188.

Completing the CMS-1500 Claim Form

Providers must use the most recent version of the CMS 1500 form. The latest version contains a scannable Quick Response code on the top right-hand corner, and the following statement at the bottom of the form - "APPROVED OMB-0938-1197 FORM 1500 (02-12)".

1. Program Block Required **-** Mark the second box labeled MEDICAID

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare#)	*(Medicaid#)*	*(ID#/DoD#)*	*(Member ID#)*	*(ID#)*	*(ID#)*	*(ID#)*

1a. Insured's ID Number (Required)
Enter the member's 10-digit MCHP ID Number as listed on the MCHP ID card. If there are questions about eligibility, please contact MCHP's Customer Service Department at 844-243-5187.

2. Patient's Name (Required)
Enter member's last name, first name, and middle initial as shown on the MCHP ID card.

3. Patient's Date of Birth (Required)
Enter the member's date of birth in a 2-digit month, 2-digit day and 2-digit year. Mark the appropriate box to indicate the patient's gender.

4. Insured's Name (Not Required)
Enter the member's last name, first name and middle initial as shown on the MCHP ID card.

5. Patient Address (Not Required)
Enter the member's street number, street name, city, state, zip code, and telephone (including area code) in the indicated fields.

6. Patient Relationship to Insured (Not Required)
Mark the second box labeled SELF.

7. Insured's Address (Not Required)

8. Reserved for NUCC Use (Not Required)

9. Other Insured's Name (Required, if applicable)

If the member has no coverage other than MCHP, leave this section blank. If other coverage exists, enter the last name, first name and middle initial of the insured. If the other insured is the member, enter "Same."

9a. Other Insured's Policy or Group Number (Required, if Applicable)
Enter the policy or group number of the other insured.

9b. Reserved for NUCC Use (Not Required)

9c. Reserved for NUCC Use (Not Required)

9d. Insurance Plan Name or Program Name (Required, if applicable)
Enter name of insurance company or program name that provides the other insurance coverage.

10. Is Patient's Condition Related to (Required, if applicable)
Mark "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10d. Claim Codes (Designated by NUCC) (Not Required)

11. Insured's Policy Group or FECA Number (Required, if applicable)

11a. Insured's Date of Birth and Sex (Required, if applicable)

11b. Other Claim ID (Designated by NUCC) (Not Required)

11c. Insurance Plan Name or Program Name (Required, if applicable)

11d. Is There Another Health Benefit Plan (Required, if applicable)
Mark the appropriate box to indicate coverage other than MCHP. If "Yes" is marked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature (Required)
If the signature is on file, then state "Signature on File". Otherwise, patient or authorized signature may be handwritten, but it must be done in black ink.

13. Insured's or Authorized Person's Signature (Required, if applicable)
If the member is under 18 years of age, then a signature is required from the insured member/authorized person. If the signature is on file, then stating that the signature is on file is acceptable. The signature may be handwritten, but it must be done in black pen.

14. Date of Illness, Injury, or Pregnancy (LMP) (Not Required)

15. Other Date (Not Required)

16. Dates Patient Unable to Work in Current Occupation (Not Required)

17. Name of Referring Provider or Other Source (Not Required)

17a. ID Number of Provider (Not Required)

17b. NPI # of Provider (Not Required)

18. Hospitalization Dates Related to Current Services (Not Required)

19. Additional Claim Information (Designated by NUCC) (Not Required)

20. Outside Lab and $ Charges (Not Required)

21. Diagnosis Codes (Required)
Enter at least one ICD diagnosis code describing the member's condition, starting with Field A. Use Fields B-L to list additional conditions as needed. Enter 0 in vertical ICD Ind. Field in the upper right-hand area of the field.

Relate diagnosis lines A – L to the lines of service in 24E. Additional information can be found in section 24E, further below.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. Medicaid Resubmission Code & Original Ref. No. (Required, if applicable)
Enter the appropriate code ("7" or "8") to indicate whether this claim is a replacement (resubmission) of a denied claim, an adjustment of a paid claim, or a void of a paid claim.

7	Replacement of Prior Claim
8	Void/Cancel Prior Claim

Enter the original MCHP Claim Number (CRN) of the denied claim being replaced or the paid claim being adjusted or voided in the field labeled "Original Reference No."

Replacement claims must represent a full replacement of the original claim, including the services that were originally filed correctly. Submitting a replacement claim with corrections only may result in a refund request.

23. Prior Authorization Number (Not Required)
MCHP's claims system will automatically match claims to approved prior authorizations (PA) when the claim is processed.

24. Service line (shaded area) (Not Required)

24A. Date(s) of Service (Required)

Enter the beginning and ending service dates in a 2-digit month, 2-digit year and 2-digit year format. Do not overlap dates of service.

DO:

Line	From	To
1	01/1/19	01/15/19
2	01/16/19	01/31/19

DON'T

Line	From	To
1	01/01/19	01/15/19
2	01/15/19	01/31/19

24B. Place of Service (Required)
Enter the two-digit code that describes the place of service. Place of service 12 = Home.

24C. EMG – Emergency Indicator (Not Required)

24D. Procedures, Services, or Supplies (Required)
Enter the CPT or HCPCS procedure code that identifies the service provided. Enter the appropriate modifier in the Modifier Field. See General Information section of this guide for procedure code and modifier information.

Use the **Units** field to indicate the number of days represented by the dates in the dates of service field. i.e. 01/01/2019 – 01/15/2019 = 15 Units. Do not use a date span, if services were not provided on all dates in the date span.

24E. Diagnosis Pointer (Required)
Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), not the diagnosis code itself. If more than one letter is entered, do not separate letters with commas.

24F. $ Charges (Required)
Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. i.e. if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

24G. Days or Units (Required)
Enter the number of days represented by the dates in the dates of service field. i.e. 01/01/2019 – 01/15/2019 = 15 Units. Do not use a date span, if services were not provided on all dates in the date span.

24H. EPSDT/Family Planning (Not Required)

24I. ID Qualifier (Required)
(SHADED AREA) Enter ZZ in the shaded area.

24J. Rendering Provider ID # (Required)
(SHADED AREA) – Use for Taxonomy Code Reporting
Enter rendering provider's 10-digit alpha-numeric taxonomy code as reflected in AHCA's Provider Master List.

24J. Rendering Provider ID # (Required)
(NON-SHADED AREA) – RENDERING PROVIDER ID #
Enter the rendering provider's 10-digit NPI. If provider does not have an NPI number, see instructions for obtaining an NPI in the general information section of this guide.

25. Federal Tax ID Number (Required)
Enter the tax ID number and mark the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number, and mark the box labeled "SSN".

26. Patient's Account Number (Not Required)
This is a number that the provider has assigned to uniquely identify a claim or account in the provider's records. MCHP will report this number in correspondence, including the Remittance Advice, to provide a reference to the provider's own accounting or tracking system.

27. Accept Assignment (Required)
Mark the box labeled YES.

28. Total Charge (Required)
Enter the total for all charges for all lines on the claim.

29. Amount Paid (Required, if applicable)
Enter the total amount that the provider has been paid for this claim by all sources other than MCHP.

30. Reserved for NUCC Use (Not required)

31. Signature and Date (Required)
The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable. Enter the date on which the claim was signed. The signature may be handwritten, but it must be done in black pen.

32. Service Facility Location Information (Not Required)

32a. Service Facility NPI # (Not Required)

32b. Service Facility (Not Required)

33. Billing Provider Name, Address and Phone # (Required)
Enter the provider name, address, and phone number. If a group is billing, enter the group name, address, and phone number.

33a. Billing Provider NPI # (Required)

33b. Other ID (Not Required)