

## Payment Request for Long Term Care (25-1) Completion

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1



The *Payment Request for Long Term Care (25-1)* is used to submit claims for Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) services.

Most claims for these services may also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual.

For additional billing information, refer to the *Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions* and *Payment Request for Long Term Care (25-1): Tips for Billing* sections in this manual.

# Payment Request for Long Term Care (25-1) Completion

6 FASTEN HERE

DO NOT STAPLE IN BAR AREA

1 CLAIM CONTROL NUMBER . FOR F.I. USE ONLY  
1

PROVIDER'S NAME, ADDRESS, ZIP CODE

1A

2 Provider Number  
2

128 Zip Code

**PAYMENT REQUEST FOR LONG TERM CARE**  
 STATE OF CALIFORNIA  
 DEPARTMENT OF HEALTH  
 CARE SERVICES  
 SEE YOUR PROVIDER MANUAL FOR ASSISTANCE  
 REGARDING THE COMPLETION OF THIS FORM

PLEASE TYPE ALL REQUIRED INFORMATION  
 ← Typewriter Alignment →

|                         |   |                           |   |                    |   |                 |   |                    |  |  |  |
|-------------------------|---|---------------------------|---|--------------------|---|-----------------|---|--------------------|--|--|--|
| 1                       | 3 | 4                         | 5 | 6                  | 7 | 8               | 9 | 10                 |  |  |  |
| DELETE PATIENT NAME     |   | 5 MEDICAL ID NUMBER       |   | 6 YR. OF BIRTH     |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 14 PATIENT STATUS  |   | 16 ACCOM. CODE  |   | 18 GROSS AMOUNT    |  | 18A PATIENT LIABILITY/ MEDICARE DEDUCT |  |
| 11                      |   | 12                        |   | 13                 |   | 14              |   | 15                 |  | 16                                     |  |
| DELETE PATIENT NAME     |   | 24 MEDI-CAL ID NUMBER     |   | 26 YR. OF BIRTH    |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 33 PATIENT STATUS  |   | 35 ACCOM. CODE  |   | 37 GROSS AMOUNT    |  | 38 PATIENT LIABILITY/ MEDICARE DEDUCT  |  |
| 22                      |   | 23                        |   | 24                 |   | 25              |   | 26                 |  | 27                                     |  |
| DELETE PATIENT NAME     |   | 43 MEDI-CAL ID NUMBER     |   | 44 YR. OF BIRTH    |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 52 PATIENT STATUS  |   | 54 ACCOM. CODE  |   | 56 GROSS AMOUNT    |  | 57 PATIENT LIABILITY/ MEDICARE DEDUCT  |  |
| 3                       |   | 4                         |   | 5                  |   | 6               |   | 7                  |  | 8                                      |  |
| DELETE PATIENT NAME     |   | 62 MEDI-CAL ID NUMBER     |   | 64 YR. OF BIRTH    |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 71 PATIENT STATUS  |   | 73 ACCOM. CODE  |   | 75 GROSS AMOUNT    |  | 76 PATIENT LIABILITY/ MEDICARE DEDUCT  |  |
| 4                       |   | 5                         |   | 6                  |   | 7               |   | 8                  |  | 9                                      |  |
| DELETE PATIENT NAME     |   | 81 MEDI-CAL ID NUMBER     |   | 82 YR. OF BIRTH    |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 90 PATIENT STATUS  |   | 92 ACCOM. CODE  |   | 94 GROSS AMOUNT    |  | 95 PATIENT LIABILITY/ MEDICARE DEDUCT  |  |
| 5                       |   | 6                         |   | 7                  |   | 8               |   | 9                  |  | 10                                     |  |
| DELETE PATIENT NAME     |   | 100 MEDI-CAL ID NUMBER    |   | 102 YR. OF BIRTH   |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 109 PATIENT STATUS |   | 111 ACCOM. CODE |   | 113 GROSS AMOUNT   |  | 114 PATIENT LIABILITY/ MEDICARE DEDUCT |  |
| 6                       |   | 3                         |   | 4                  |   | 5               |   | 6                  |  | 7                                      |  |
| DELETE PATIENT NAME     |   | 100 MEDI-CAL ID NUMBER    |   | 102 YR. OF BIRTH   |   | TAR CONTROL NO. |   | MEDICAL RECORD NO. |  | ATTED. M.D. PROVIDER NUMBER            |  |
| BILL'G LIMIT EXCEPTIONS |   | DATE OF SERVICE FROM THRU |   | 109 PATIENT STATUS |   | 111 ACCOM. CODE |   | 113 GROSS AMOUNT   |  | 114 PATIENT LIABILITY/ MEDICARE DEDUCT |  |
| 117                     |   | 118                       |   | 119                |   | 120             |   | 121                |  | 122                                    |  |
| ATTACH. MEDS            |   | PROV. REF. NO.            |   | DATE BILLED        |   | F.I. USE ONLY   |   | 123                |  | 124                                    |  |
| 125                     |   | 126                       |   | 127                |   | 128             |   | 129                |  | 130                                    |  |

PLEASE DO NOT MARK IN SHADED AREAS

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

126A

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.  
 127  
 SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

Figure 1. Payment Request for Long Term Care (25-1).

**Explanation of Form Items**

The following item numbers and descriptions correspond to the sample *Payment Request for Long Term Care (25-1)* claim form on the previous page for completing Medi-Cal claims and Medi-Cal Part A coinsurance and Part B crossover claims. All items must be completed unless otherwise noted in these instructions. Note that only one month's service can be billed on each line.

All instructions are applicable to both paper and CMC claims except where noted. For general paper claim and CMC billing instructions, review the *Forms: Legibility and Completion Standards* section in this manual and the *CMC* section in the Part 1 manual.

**Required Claim Form Items**

A quick reference of required claim form items for Medi-Cal per diem billing, Medicare Part A coinsurance and Part B deductible residual amount billing appears at the end of this section (see *Figure 2*).

**Note:** When billing for Medicare/Medi-Cal crossover claims, follow the directions in either the *Part A Coinsurance Claim Description* or the *Part B Crossover Claim Description* column. When billing for straight Medi-Cal claims, follow the directions in the *Medi-Cal Claim Description* column.

| <u>Item</u> | <u>Medi-Cal Claim Description</u>  | <u>Part A Coinsurance Claim Description</u> | <u>Part B Crossover Claim Description</u> |
|-------------|--|---|---|
| 1.          | <b>CLAIM CONTROL NUMBER.</b> For use by the <b>DHCS Fiscal Intermediary (FI)</b> only. DO NOT mark in this area. A unique 13-digit number, assigned by <b>the FI</b> to track each claim, will be entered here when <b>the FI</b> receives the claim.  | Same as Medi-Cal                            | Same as Medi-Cal                          |
| 1A.         | <b>PROVIDER NAME, ADDRESS.</b> Enter your name and address. Please confirm that this information is correct before submitting claims.<br><br><b>ZIP CODE</b> (Box 128). Enter the nine-digit ZIP code of the facility.<br><br><b>Note:</b> The nine-digit ZIP code entered in this box must match the biller's zip code on file for claims to be reimbursed correctly. | Same as Medi-Cal                            | Same as Medi-Cal                          |

| <u>Item</u> | <u>Medi-Cal Claim Description</u>  | <u>Part A Coinsurance<br/>Claim Description</u> | <u>Part B Crossover<br/>Claim Description</u> |
|-------------|--|---|---|
| 2.          | <p><b>PROVIDER NUMBER.</b> Enter your National Provider Identifier (NPI). Be sure to include all ten characters of the number.</p> <p>Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that bill with anything other than an NPI will be denied.</p> <p><b><u>Note to CMC Users:</u></b> Anytime a provider number is changed, a new provider application/agreement form must be submitted to the CMC unit to allow continued CMC billing using the new provider number. (For more information, refer to the <i>CMC Enrollment Procedures</i> section in the Part 1 manual.)</p> | Same as Medi-Cal                                | Same as Medi-Cal                              |
| 3.          | <p><b>DELETE.</b> If an error has been made for a particular patient, enter an “X” in this space to delete both the upper and lower line. Enter the correct billing information on another line. When the <i>Delete</i> box is marked “X”, the information on both lines will be “ignored” by the system and will not be entered as a claim line.</p> <p><b><u>Note to CMC Users:</u></b> <i>Delete</i> boxes do not appear on CMC claims.</p>   | Same as Medi-Cal                                | Same as Medi-Cal                              |

| <u>Item</u> | <u>Medi-Cal Claim Description</u>   | <u>Part A Coinsurance Claim Description</u> | <u>Part B Crossover Claim Description</u> |
|-------------|---|---|---|
| 4.          | <b>PATIENT NAME.</b> Enter the patient's last name, first name, and if known, middle initial. Avoid nicknames or aliases.   | Same as Medi-Cal                            | Same as Medi-Cal                          |
| 5.          | <b>MEDI-CAL IDENTIFICATION NUMBER.</b> Enter the recipient ID number as it appears on the Benefits Identification Card (BIC).<br><br><b><u>Note to CMC Users:</u></b> Enter the recipient ID number with or without leading zeros.                          | Same as Medi-Cal                            | Same as Medi-Cal                          |
| 6.          | <b>YEAR OF BIRTH.</b> Enter the patient's year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth (CCYY) in the <i>Explanations</i> area (Box 126a). | Same as Medi-Cal                            | Same as Medi-Cal                          |
| 7.          | <b>SEX.</b> Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the BIC.  | Same as Medi-Cal                            | Same as Medi-Cal                          |

| <u>Item</u> | <u>Medi-Cal Claim Description</u>  | <u>Part A Coinsurance<br/>Claim Description</u> | <u>Part B Crossover<br/>Claim Description</u> |
|-------------|--|---|---|
| 8.          | <b>TAR CONTROL NUMBER.</b> For services requiring a <i>Treatment Authorization Request</i> (TAR), enter the nine-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the TAR must match the claim. Be sure the billed dates fall within the TAR authorized dates.   | Leave Blank                                     | Leave Blank                                   |
| 9.          | <b>MEDICAL RECORD NUMBER.</b> This is an optional field that will help you to easily identify a recipient on RTDs and RADs. Enter the patient's medical record number or account number in this field (maximum of five characters – either numbers or letters may be used). Whatever you enter here will appear on the RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD) Completion</i> and the <i>Remittance Advice Details (RAD)</i> sections in this manual for more information. | Same as Medi-Cal                                | Same as Medi-Cal                              |
| 10.         | <b>ATTENDING M.D. PROVIDER NUMBER.</b> Enter the physician's <b>NPI</b> . Be sure the attending physician's <b>NPI</b> is entered on a(n): <ul style="list-style-type: none"> <li>• Admit claim</li> <li>• Initial Medi-Cal claim for a Medicare/ Medi-Cal crossover patient</li> <li>• Claim when there is a change in the attending physician's provider number</li> </ul>   | Same as Medi-Cal                                | Same as Medi-Cal                              |

| <u>Item</u> | <u>Medi-Cal Claim Description</u>   | <u>Part A Coinsurance Claim Description</u>   | <u>Part B Crossover Claim Description</u>  |
|-------------|---|---|--|
| 11.         | <p><b>BILLING LIMIT EXCEPTIONS (DELAY REASON CODE).</b> If there is an exception to the six-month billing limitation from the month of service, enter the appropriate delay reason code and include the required documentation. (See the <i>Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions</i> section in this manual for a complete listing of delay reason codes.) The appropriate documentation must be supplied to justify the exception to the billing limitations.</p> | <p>Enter delay reason code number 7 in this box if the Medi-Cal claim is submitted more than six months from the month of service. Attach a copy of the Medicare EOMB/RA.</p> | <p>Same as Part A coinsurance.</p>   |
| 12./13.     | <p><b>DATE OF SERVICE.</b> Enter the period billed using a six-digit MMDDYY [Month, Day, Year] format for the FROM and THRU dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, April 5, 2007, is written 040507</p> <p><b>Note:</b> When a patient is discharged, the thru date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.</p>                  | <p>Same as Medi-Cal</p> <p><b>Note:</b> Dates of service reflect only those dates covered by coinsurance. No TAR required.</p>  | <p>Only a one-month period may be billed on any one billing line. If the Part B Medi-Cal Crossover service involves only one day, enter the <u>same</u> date in both the FROM and THRU boxes. If the services were performed over a range of dates in the same month, the FROM date is the first service date and the last service date as appears on the Medicare form.</p> |

| <u>Item</u> | <u>Medi-Cal Claim Description</u>   | <u>Part A Coinsurance Claim Description</u> | <u>Part B Crossover Claim Description</u> |
|-------------|---|---|---|
| 14.         | <b>PATIENT STATUS.</b> Enter the appropriate patient status code from the list below: | Same as Medi-Cal                            | Same as Medi-Cal                          |
|             | <u>Code</u> <u>Patient Status</u>   |   |   |
|             | 00    Still under care  |   |   |
|             | 01    Admitted  |   |   |
|             | 02    Expired   |   |   |
|             | 03    Discharged to acute hospital  |   |   |
|             | 04    Discharged to home  |   |   |
|             | 05    Discharged to another LTC facility  |   |   |
|             | 06    Leave of absence to acute hospital (bed hold)                                   |   |   |
|             | 07    Leave of absence to home  |   |   |
|             | 08    Leave of absence to acute hospital/ discharged                                  |   |   |
|             | 09    Leave of absence to home/discharged   |   |   |
|             | 10    Admitted/expired  |   |   |
|             | 11    Admitted/discharged to acute hospital   |   |   |
|             | 12    Admitted/discharged to home   |   |   |
|             | 13    Admitted/discharged to another LTC facility                                     |   |   |
|             | 32    Transferred to TC status in same facility                                       |   |   |

The patient status code must agree with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).

**Note:** **FI** does not require a copy of Form MC-171 (*Notification of Patient Admission, Discharge, or Death*) to be attached to the *Payment Request for Long Term Care* form.



| <u>Item</u> | <u>Medi-Cal Claim Description</u>  | <u>Part A Coinsurance<br/>Claim Description</u> | <u>Part B Crossover<br/>Claim Description</u> |
|-------------|--|---|---|
| 15.         | <p><b>ACCOMODATION CODE.</b> Enter the appropriate accommodation code for the type of care billed, as listed in the <i>Accommodation Codes for Long Term Care</i> section in this manual.</p> <p><b>Note:</b> <b>FI</b> does not require that a copy of Form HS 231 (<i>Certification for Special Program Services</i>) be attached to the <i>Payment Request for Long Term Care (25-1)</i>. Form HS 231 should be attached to the LTC TAR sent to the Medi-Cal field office.</p>  | Same as Medi-Cal                                | Leave Blank                                   |
| 16.         | <p><b>PRIMARY DX (DIAGNOSIS) CODE.</b> Enter the Primary ICD-9-CM diagnosis code (<i>International Classification of Diseases – 9th Revision, Clinical Modification</i>) for the following:</p> <ul style="list-style-type: none"> <li>• Admit claims</li> <li>• Initial Medi-Cal claim for Medicare/Medi-Cal crossover patient</li> <li>• Change in diagnosis</li> </ul> <p><b>Note:</b> ICD-9-CM coding must be three, four or five digits with the fourth and fifth digits included if present. The vertical line serves as the decimal point. Do not enter the decimal point when entering this code.</p> <p>Current copies of the ICD-9-CM codes may be ordered from:</p> <p>PMIC<br/>4727 Wilshire Blvd., Suite 300<br/>Los Angeles, CA 90010<br/>1-800-633-7467</p> | Same as Medi-Cal                                | Leave Blank                                   |

| Item | Medi-Cal Claim Description   | Part A Coinsurance Claim Description  | Part B Crossover Claim Description  |
|------|--|---|---|
| 17.  | <p><b>GROSS AMOUNT.</b> When billing for full Medi-Cal coverage, compute the gross amount by multiplying the number of days times the appropriate Medi-Cal daily rate for the accommodation code listed.</p> <p>When entering the gross amount, do not use symbols (\$) or (.). Use this method in entering all dollar amounts on the <i>Payment Request for Long Term Care (25-1)</i> form.</p>   | <p>Multiply the per diem rate allowed by Medicare, times the total coinsurance days being billed and enter the total.</p> | <p>Enter the amount <u>allowed</u> by Medicare for these services directly from the Medicare EOMB/RA.</p>   |
| 18.  | <p><b>PATIENT LIABILITY/MEDICARE DEDUCT.</b> Enter the recipient's net Share of Cost (SOC) liability. The recipient's net SOC liability is the amount billed to the recipient. The recipient's net SOC liability is determined by subtracting from the recipient's original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient's SOC liability.</p> <p>For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items "not covered" by Medi-Cal. A description of non-covered services is included in the <i>Share of Cost (SOC): 25-1 for Long Term Care</i> section of this manual.</p> <p>The PATIENT LIABILITY (SOC) entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the <i>DHS 6114</i> form, <i>Item 15</i>. (See the <i>Share of Cost [SOC]: 25-1 for Long Term Care</i> section in this manual for an example.)</p> <p>When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the <i>Explanations</i> area.</p> <p>The PATIENT LIABILITY (SOC) amount is deducted from the amount billed to Medi-Cal.</p> | <p>Same as Medi-Cal, except may leave blank if SOC is zero.</p>   | <p>Medicare deductible: For a Part B crossover claim, this field is for Medicare deductible information only. Enter the deductible found on the Medicare EOMB/RA. If the Medicare deductible has already been met, leave this area blank.</p> <p>SOC: For Part B crossover claims, do not show SOC (patient liability) information in this box. When the Medi-Cal eligibility verification system shows the recipient has an SOC, enter that information in the <i>Explanations</i> area of the claim. Refer to the <i>Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples</i> section in this manual for a sample.</p> |

| Item | <u>Medi-Cal Claim Description</u>   | <u>Part A Coinsurance Claim Description</u>  | <u>Part B Crossover Claim Description</u>   |
|------|---|--|---|
| 18A. | <b>MEDICARE TYPE.</b> Leave blank for Medi-Cal-only claims.   | Enter the capital letter "A" to indicate that the claim is for a Part A coinsurance billing.   | Enter the capital letter "B" to indicate that the claim is for a Part A coinsurance billing.  |
| 19.  | <p><b>OTHER COVERAGE.</b> Enter the amount paid by other insurance carrier(s) for the period billed, if applicable. Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs.</p> <p><b>Note:</b> If the Medi-Cal eligibility verification system indicates a scope of coverage code "L" for the recipient, providers must bill other insurance carriers prior to billing Medi-Cal. For more information about OHC, refer to the <i>Other Health Coverage (OHC)</i> section in this manual.</p> | <p><b>Note:</b> A copy of the Medicare EOMB/RA must be attached to the Payment Request form.</p> <p>Enter the amount actually paid by the Medicare intermediary for the coinsurance days being billed. Attach a copy of the EOMB/RA to the Payment Request form.</p> | <p><b>Note:</b> A copy of the Medicare EOMB/RA must be attached to the Payment Request form.</p> <p>Enter the amount Medicare paid for service(s) as shown on the EOMB/RA. Attach a copy of the EOMB/RA to the Payment Request form. Do not attach a copy of the UB-04.</p> <p>If there is a "contract adjusted amount" on the EOMB/RA, add this figure to the Medicare paid amount and enter the total in the <i>Other Coverage</i> field.</p> |
| 20.  | <p><b>NET AMOUNT BILLED.</b> Enter the amount requested for this billing. To compute the net amount, subtract patient liability and OHC (if any) from the gross amount billed. If the net amount billed computes to \$0.00, enter the amount as "0000." Do not leave blank. (Gross Amount – Patient Liability = Net Amount.)</p>  | <p>Enter the amount billed to Medi-Cal (coinsurance) as shown on the EOMB/RA from the Medicare intermediary, less any patient liability applied to this billing line.</p>  | <p>Enter the portions to be billed to Medi-Cal (coinsurance plus any Medicare deductible as shown on EOMB/RA from the Medicare intermediary, minus any patient liability as shown in the <i>Explanations</i> area.)</p>   |

| <u>Item</u>   | <u>Medi-Cal Claim Description</u>   | <u>Part A Coinsurance Claim Description</u> | <u>Part B Crossover Claim Description</u> |
|---|---|---|---|
| 21.   | <b>M.D. CERTIFICATION.</b> Not required.  | Not required.                               | Not required.                             |
| 22. –<br>116.   | <b>ADDITIONAL CLAIM LINES.</b> The Payment Request form may be used to bill services for as many as six patients. Bill only one month's services on each line.  | Same as Medi-Cal.                           | Same as Medi-Cal.                         |
| 117.  | <b>ATTACHMENTS.</b> Enter an "X" if attachments are included with the claim. Leave blank if not applicable.   | Same as Medi-Cal.                           | Same as Medi-Cal.                         |
| <p><b>Reminder:</b> If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied.</p> <p><b>Note to CMC Users:</b> This box does not appear in the CMC 02 local format. Claims that require certain documentation (Medicare EOMB/RA, proof of denial from other coverage, etc.) must be submitted hard copy, or electronically, using the ASC X12N 837 v.4010A1 Institutional format. However, some documentation (for example, detailed SOC expenditures) can be entered in the CMC <i>Remarks</i> area.</p> <p>For more information regarding attachment submission, refer to the Billing Instructions of the <i>837 Version 4010A1 Health Care Claim Companion Guide</i> on the Medi-Cal Web site at <a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov</a>.</p> |   |   |   |
| 118.  | <b>PROVIDER REFERENCE NO.</b> Enter any number up to seven digits to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. This number will be referenced by <b>the FI</b> on any forms sent to you that pertain to the billing data on the form. It will not be included on the RAD. | Same as Medi-Cal.                           | Same as Medi-Cal.                         |
| 119.  | <b>DATE BILLED.</b> In six-digit format, enter the date the claim is submitted for Medi-Cal payment.  | Same as Medi-Cal.                           | Same as Medi-Cal.                         |
| 120. –<br>126.  | <b>FI USE ONLY.</b> Leave blank   | Same as Medi-Cal.                           | Same as Medi-Cal.                         |

| <u>Item</u> | <u>Medi-Cal Claim Description</u>   | <u>Part A Coinsurance Claim Description</u>                       | <u>Part B Crossover Claim Description</u>                |
|-------------|---|---|--|
| 126A.       | <p><b>EXPLANATIONS.</b> Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area.</p> <p><b>Note to CMC Users:</b> <i>Explanations</i> information can also be submitted on a CMC format. CMC providers using the CMC 02 local format may use the optional <i>Remarks</i> area for claims that require additional information or justification. CMC providers may call 1-800-541-5555 for help in using the <i>Remarks</i> area.</p>   | <p>Same as Medi-Cal. Use for explanations of SOC adjustments.</p> | <p>Same as Medi-Cal. Enter Medi-Cal SOC amount here.</p> |
| 127.        | <p><b>SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER (REPRESENTATIVE).</b> The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only.</p> <p>An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file at <b>the FI</b>.</p> <p><b>Note to CMC Users:</b> CMC claims do not require signatures. However, a signed <i>Claim Certification and Control Sheet</i> (Form 80-1) is required with each tape submission. (For more information, refer to the <i>CMC</i> section in the Part 1 manual.)</p> | <p>Same as Medi-Cal.</p>  | <p>Same as Medi-Cal.</p>                                 |

| <b>REQUIRED CLAIM FORM ITEMS</b>   |   |   |   |
|------------------------------------|---|---|---|
| <b><u>CLAIM FORM ITEM</u></b>      | <b><u>MEDI-CAL PER DIEM</u></b>   | <b><u>PART A COINSURANCE</u></b>        | <b><u>PART B CROSSOVER</u></b>  |
| DELETE BOX                         | When Necessary  | When Necessary                          | When Necessary  |
| PATIENT NAME                       | Required  | Required                                | Required  |
| RECIPIENT ID NO.                   | Required  | Required                                | Required  |
| YEAR OF BIRTH                      | Required  | Required                                | Required  |
| SEX                                | Required  | Required                                | Required  |
| TAR CONTROL NO.                    | Required  | Leave Blank                             | Leave Blank   |
| MEDICAL RECORD NO.                 | Optional  | Optional                                | Optional  |
| ATTENDING M.D. NO.                 | Required for Admit/Change   | Required for Admit/Change               | Required  |
| DELAY REASON CODE                  | When Necessary  | When Necessary                          | When Necessary  |
| DATE OF SERVICE                    | Required  | Required                                | Required  |
| PATIENT STATUS                     | Required  | Required                                | Leave Blank   |
| ACCOMMODATION CODE                 | Required  | Required                                | Leave Blank   |
| PRIMARY DX CODE                    | Required for Admit/Change   | Required for Admit/Change               | Leave Blank   |
| GROSS AMOUNT                       | Required  | Required                                | Required  |
| PATIENT LIABILITY MEDICARE DEDUCT. | Medi-Cal Liability Share of Cost (SOC) Amount or "0". Do not leave blank. | Medi-Cal Liability (SOC) when not zero. | Medicare Deductible Only. Enter SOC in <i>Explanations</i> area of claim. |
| MEDICARE TYPE                      | Leave Blank   | Required (A)                            | Required (B)  |
| OTHER COVERAGE                     | Blank Unless Other Health Insurance Billed                                | Required                                | Required  |
| NET AMT. BILLED                    | Required  | Required                                | Required  |

Figure 2. Required Claim Form Items for Medi-Cal Per Diem Billing and Medicare Part A Coinsurance Billing/Medicare.