2017 Claim Form

1. Choose one:
☐ Family Planning Program: XIX
☐ DSHS Family Planning Program (DFPP)

1a. DFPP only:
☐ Partial Pay
☐ No Pay

2a. Billing Provider TPI

2b. Billing provider NPI

3. Provider Name

4. Eligibility Date (MM/DD/CCYY)

5. DSHS Client No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial)

7. Address (Street, City, State)

7a. ZIP Code

8. County of Residence

9. Date of Birth (MM/DD/CCYY)

10. Sex
☐ F ☐ M

11. Patient Status
☐ New Patient ☐ Established Patient

12. Patient's Social Security Number
- -

13. Race (Code No.): ☐
White (1) Black (2) AmIndian/AlaskNat (4)
Asian (5) Unk/Not Rep (6) NatHawaii/PacIsland (7)
More than one race (8)

13a. Ethnicity: ☐
Hispanic (5)
Non-Hispanic (0)

14. Marital Status: ☐
(1) Married
(2) Never Married
(3) Formerly Married

15. Family Income (All): $

15a. Family Size

16. Number Times Pregnant

17. Number Live Births

18. Number Living Children

19. Primary Birth Control Method Before Initial Visit ☐

20. Primary Birth Control Method at End of this Visit ☐

a=Oral Contraceptive
b=1-Month hormonal injection
c=3-Month hormonal injection
d=Cervical cap/diaphragm
e=Abstinence
f= Hormonal Implant
g=Male condom
h=Female condom
i=Hormonal/ Contraceptive patch
j=Spermicide (used alone)
k=Intrauterine device (IUD)
l=Vaginal ring
m=Fertility awareness method (FAM)
n=Sterilization
o=Contraceptive sponge
p=Other method /Withdrawal
q=Method unknown
r=No method (if used for No. 20, must complete No. 21)

21. If No Method Used at End of This Visit, Give Reason (Required only if No. 20 = r) ☐
a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Prg; e=Infertile; f=Rely on Partner; g=Medical

22. Is There Other Insurance Available?
☐ Y (If Y, Complete Items 23-25a.) ☐ N

23. Other Insurance Name and Address

24a. Insured's Policy/Group No.

24b. Benefit Code

25. Other Insurance Pd. Amt.
$

25a. Date of Notification

26. Name of Referring Provider

27a. Referring Other ID

27b. Referring NPI

28. Level of Practitioner
☐ Physician ☐ Nurse ☐ Mid-Level ☐ Other

29. Diagnosis Code (Relate A-L to service line 32E) ICD Ind.
A. _____ B. _____ C. _____ D. _____
E. _____ F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

30. Authorization Number

31. Date of Occurrence (MM/DD/CCYY)

32. A Dates of Service From MM DD CCYY / To MM DD CCYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS Modifier	E Ex. Ref. (29)	F Units or Days (Quantity)	G $ Charges	H Performing Provider No.
1							TPI / NPI
2							TPI / NPI
3							TPI / NPI
4							TPI / NPI
5							TPI / NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed
$

36. **Total Charges**

37. Signature of Physician or Supplier
Date:
Signed:

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

38a. NPI

38b. Other ID

39. Physician's, Supplier's Billing Name, Address, ZIP Code & Phone No.

2017 Claim Form Instructions

Block No.	Description	Guidelines	Required (Paper)
1	Program	Check the box for the specific program to which these services are billed: • Family Planning Program: XIX (Check this box for Title XIX family planning services and for Healthy Texas Women [HTW] services) • DSHS Family Planning Program (DFPP)	XIX, DFPP (All)
2a	Billing provider TPI	Enter the billing provider's nine-digit TPI.	All
2b	Billing provider NPI	Enter the billing provider's NPI.	All
3	Provider name	Enter the provider's name as enrolled with TMHP.	All
4	Eligibility date (DFPP)	Enter the date (MM/DD/CCYY) this client was designated eligible for DFPP services. For DFPP, the eligibility date can be found on the following forms: • INDIVIDUAL Eligibility Form (EF05-14215) • HOUSEHOLD Eligibility Form (EF05-14214) • HOUSEHOLD Eligibility Worksheet (EF05-13227) • An approved DSHS substitute	DFPP
5	DSHS Client no. (Medicaid PCN if XIX)	If previous DFPP claims or encounters have been submitted to TMHP, enter the client's nine-digit DSHS client number, which begins with "F." If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form. If this is a new client, without Medicaid, leave this block blank and TMHP will assign a DSHS client number for the client.	XIX
6	Patient's name (last name, first name, middle initial)	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider's records, if DFPP.	All
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	All
7a	ZIP Code	Enter the client's ZIP Code.	All
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	All
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	All
10	Sex	Indicate the client's sex by checking the appropriate box.	All
11	Patient status	Indicate if this is the client's first visit to this provider (new patient) or if this client has been to this provider previously (established patient). If the provider's records have been purged and the client appears to be new to the provider, check "New Patient."	All
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	All

Block No.	Description	Guidelines	Required (Paper)
13	Race (Code No.)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	All
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	All
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	All
15	Family income (all)	*DFPP:* • Use the gross monthly income calculated and reported on the INDIVIDUAL Eligibility Form (EF05-14215), the HOUSEHOLD Eligibility Form (EF05-14214), or the HOUSEHOLD Eligibility Worksheet (EF05-13227). *Title XIX:* Enter the gross monthly income reported by the client. Be sure to include all sources of income If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.	All
15a	Family size	DFPP: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	All
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	XIX
17	Number live births	Enter the number of live births for this client. If male, enter zero.	XIX
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	XIX
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	XIX
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	XIX
21	If no method used at end of this visit, give reason (required only if No. 20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from this block (a through g).	XIX (only if No. 20=r)

Block No.	Description	Guidelines	Required (Paper)
22	Is there other insurance available?	Check the appropriate box.	Optional
23	Other insurance name and address	Enter the name and address of the health insurance carrier.	Optional
24a	Insured's policy/group no.	Enter the insurance policy number or group number.	Optional
24b	Benefit code	Benefit code, if applicable for the billing or performing provider.	Optional
25	Other insurance paid amount	Enter the amount paid by the other insurance company. If payment was denied, enter "Denied" in this block.	Optional
25a	Date of notification	Enter the date of the other insurance payment or denial in this block. This must be in the format of MM/DD/CCYY.	Optional
26	Name of referring provider	If a non-family planning service is being billed, and the service requires a referring provider, enter the provider's name.	XIX (if available)
27b	Referring NPI	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX
28	Level of practitioner	Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as "Physicians." Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing encounters are correctly categorized as "Midlevel." Encounters provided by a registered nurse or a licensed vocational nurse would be categorized as "Nurse." Encounters provided by staff not included in the preceding classifications would be correctly categorized as "Other." If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any DFPP funding.	DFPP
29	Diagnosis code (Relate Items A-L to service line 32E)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.	All
30	Authorization number	Enter the authorization number for the client, if appropriate.	Optional
31	Date of occurrence	Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This block should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed.	All, if billing complications

Block No.	Description	Guidelines	Required (Paper)
32A	Dates of service	Enter the dates of service (DOS) for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/2010). *Electronic Billers* Medicaid does not accept multiple (to–from) dates on a single-line detail. Bill only one date per line. **NDC** In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. **Example:** N400409231231	All
32B	Place of service	Enter the appropriate POS code for each service from the POS table in the Texas Medicaid Provider Procedures Manual. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	All
32C	Reserved for local use	Leave this block blank. **Note:** *TOS codes are no longer required for claims submission.*	Optional
32D	Procedures, services, or supplies CPT/HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed. **NDC** **Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.	All
32E	Dx. ref. (29)	Enter the diagnosis line item reference (A-L) for each service or procedure as it relates to each ICD diagnosis code identified in Block 29. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 29 only. Do not enter diagnosis codes in Form Field 32E.	All
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** **Optional:** In the shaded area, enter the NDC unit of measurement code.	All
32G	$ Charges	Indicate the charges for each service listed (quantity multiplied by reimbursement rate). Charges must not be higher than fees charged to private-pay clients.	All

Block No.	Description	Guidelines	Required (Paper)
32H (a)	Performing provider number (XIX only)—TPI	Members of a group practice (except pathology and renal dialysis groups) must identify the nine-digit TPI of the provider within the group who performed the service. **Note:** *To avoid unnecessary denials, DFPP providers should include the performing provider's TPI on the claim. Although not required for DFPP claims, if a claim or encounter that was submitted through DFPP is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX
32H (b)	Performing provider number (XIX only)—NPI	**Optional:** Members of a group practice (except pathology and renal dialysis groups) must identify NPI of the provider within the group who performed the service. **Note:** *To avoid unnecessary denials, DFPP providers should include the performing provider's NPI on the claim. Although not required for DFPP claims, if a claim or encounter that was submitted through DFPP is later determined eligible to be paid under Title XIX, the claim will be denied if the performing provider information is missing.*	XIX
33	Federal tax ID number/EIN (optional)	Enter the federal TIN (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP.	XIX, DFPP
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	Optional
35	Patient copay assessed (DFPP)	If the client was assessed a copayment (DFPP), enter the dollar amount assessed. If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients. Copayment must not exceed $30.00 for DFPP patients.	DFPP
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	All
37	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on file" in place of the provider's signature if the billing service obtains and retains on file a letter signed and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	All
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.	XIX

Block No.	Description	Guidelines	Required (Paper)
38a	NPI	Enter the NPI of the provider where services were rendered (if other than home or office).	XIX
39	Physician's, supplier's billing name, address, ZIP Code, and telephone number	Enter the billing provider name, street, city, state, ZIP Code, and telephone number.	Optional