

| | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|-------------------------|
| 2017 Claim Form | | 1. Choose one: <input type="checkbox"/> Family Planning Program: XIX <input type="checkbox"/> DSHS Family Planning Program (DFPP) | | | 1a. DFPP only: <input type="checkbox"/> Partial Pay <input type="checkbox"/> No Pay | | 2a. Billing Provider NPI | | |
| | | 3. Provider Name | | 4. Eligibility Date (MM/DD/CCYY) | | 2b. Billing Provider Taxonomy | | 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 <input type="checkbox"/> F <input type="checkbox"/> M | | 11. Patient Status <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient | | 12. Patient's Social Security Number - - | |
| 13. Race (Code No.): White (1) Black (2) Asian (5) Unk/Not Rep (6) | | | AmIndian/AlaskNat (4) 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 | | <input type="checkbox"/> | | 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 | |
| 20. Primary Birth Control Method at End of this Visit | | <input type="checkbox"/> | | 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 <input type="checkbox"/> | | | | | | | | | |
| 22. Is There Other Insurance Available? <input type="checkbox"/> Y (If Y, Complete Items 23-25a.) <input type="checkbox"/> N | | | | 23. Other Insurance Name and Address | | | | | |
| 24a. Insured's Policy/Group No. | | 24b. Provider Benefit Code | | 25. Other Insurance Pd. Amt. \$ | | 25a. Date of Notification | | | |
| 26. Name of Referring Provider | | 27a. Referring Other ID | | | 28. Level of Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Mid-Level <input type="checkbox"/> Other | | | | |
| 27b. Referring NPI | | | | | | | | | |
| 29. Diagnosis Code (Relate A-L to service line 32E) | | | | ICD Ind. | | 30. Authorization Number | | | |
| A. _____ | | B. _____ | | C. _____ | | D. _____ | | 31. Date of Occurrence (MM/DD/CCYY) | |
| E. _____ | | F. _____ | | G. _____ | | H. _____ | | | |
| I. _____ | | J. _____ | | K. _____ | | L. _____ | | | |
| 32. A | | B | C | D | | E | F | G | H |
| Dates of Service From MM DD CCYY To MM DD CCYY | | Place of Service | Type of Service | Procedures, Services, or Supplies CPT/HCPCS Modifier | | Ex. Ref. (29) | Units or Days (Quantity) | \$ Charges | Performing Provider No. |
| 1 | | | | | | | | | Perf Prov Taxonomy |
| | | | | | | | | | Perf Prov NPI |
| 2 | | | | | | | | | Perf Prov Taxonomy |
| | | | | | | | | | Perf Prov NPI |
| 3 | | | | | | | | | Perf Prov Taxonomy |
| | | | | | | | | | Perf Prov NPI |
| 4 | | | | | | | | | Perf Prov Taxonomy |
| | | | | | | | | | Perf Prov NPI |
| 5 | | | | | | | | | Perf Prov Taxonomy |
| | | | | | | | | | Perf Prov 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) | | | 39. Physician's, Supplier's Billing Name, Address, ZIP + 4 Code & Phone No. | | |
| 38a. NPI | | 38b. Other ID | | | | | | | |

2017 Claim Form Instructions

| Block No. | Description | Guidelines | Required (Paper) |
|-----------|--|---|------------------|
| 1 | Program | <p>Check the box for the specific program to which these services are billed:</p> <ul style="list-style-type: none"> 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 NPI | Enter the billing provider's NPI. | All |
| 2b | Billing provider Taxonomy | Enter the billing provider's Taxonomy Code. | All |
| 3 | Provider name | Enter the provider's name as enrolled with TMHP. | All |
| 4 | Eligibility date (DFPP) | <p>Enter the date (MM/DD/CCYY) this client was designated eligible for DFPP services.</p> <p>For DFPP, the eligibility date can be found on the following forms:</p> <ul style="list-style-type: none"> 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) | <p>If previous DFPP claims or encounters have been submitted to TMHP, enter the client's nine-digit DSHS client number, which begins with "F."</p> <p>If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form.</p> <p>If this is a new client, without Medicaid, leave this block blank and TMHP will assign a DSHS client number for the client.</p> | 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.) | <p>Indicate the client's race by entering the appropriate race code number in the box.</p> <p>Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction.</p> <p>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.</p> | All |
| 13a | Ethnicity | <p>Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box.</p> <p>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."</p> | All |
| 14 | Marital status | <p>Indicate the client's marital status by entering the appropriate marital code number in the box.</p> | All |
| 15 | Family income (all) | <p><i>DFPP:</i></p> <ul style="list-style-type: none"> 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). <p><i>Title XIX:</i> Enter the gross monthly income reported by the client. Be sure to include all sources of income</p> <p>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.</p> <p>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.</p> <p>Enter \$1.00 for clients not wishing to reveal income information.</p> | All |
| 15a | Family size | <p><i>DFPP:</i> Use the family size reported on the eligibility assessment tool.</p> <p><i>Title XIX providers:</i> Enter the number of family members supported by the income listed in Box 15. Must be at least "one."</p> | All |
| 16 | Number times pregnant | <p>Enter the number of times this client has been pregnant. If male, enter zero.</p> | XIX |
| 17 | Number live births | <p>Enter the number of live births for this client. If male, enter zero.</p> | XIX |
| 18 | Number living children | <p>Enter the number of living children this client has. This also must be completed for male clients.</p> | XIX |
| 19 | Primary birth control method before initial visit | <p>Enter the appropriate code letter (a through r) in the box.</p> | XIX |
| 20 | Primary birth control method at end of this visit | <p>Enter the appropriate code letter (a through r) in the box.</p> | XIX |
| 21 | If no method used at end of this visit, give reason (required only if No. 20=r) | <p>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).</p> | 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 | Provider Benefit Code | Benefit code, if applicable for the billing 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 | <p>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).</p> <p><i>Electronic Billers</i></p> <p>Medicaid does not accept multiple (to–from) dates on a single-line detail. Bill only one date per line.</p> <p>NDC</p> <p>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).</p> <p>Do not enter hyphens or spaces within this number.</p> <p>Example: N400409231231</p> | All |
| 32B | Place of service | <p>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.</p> | All |
| 32C | Reserved for local use | <p>Leave this block blank.</p> <p>Note: TOS codes are no longer required for claims submission.</p> | Optional |
| 32D | Procedures, services, or supplies CPT/HCPCS modifier | <p>Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed.</p> <p>NDC</p> <p>Optional: In the shaded area, enter a 1- through 12-digit NDC quantity of unit.</p> <p>A decimal point must be used for fractions of a unit.</p> | All |
| 32E | Dx. ref. (29) | <p>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.</p> <p>When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow.</p> <p>The reference letter(s) should be A-L or multiple letters as applicable.</p> <p>Diagnosis codes must be entered in Form Field 29 only. Do not enter diagnosis codes in Form Field 32E.</p> | All |
| 32F | Units or days (quantity) | <p>If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).</p> <p>NDC</p> <p>Optional: In the shaded area, enter the NDC unit of measurement code.</p> | All |
| 32G | \$ Charges | <p>Indicate the charges for each service listed (quantity multiplied by reimbursement rate). Charges must not be higher than fees charged to private-pay clients.</p> | All |

| Block No. | Description | Guidelines | Required (Paper) |
|-----------|---|---|------------------|
| 32H (a) | Performing Provider Taxonomy (XIX only) | Members of a group practice (except pathology and renal dialysis groups) must identify the taxonomy of the provider within the group who performed the service. Note: To avoid unnecessary denials, DFPP providers should include the performing provider's taxonomy 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 NPI number (XIX only) | Optional: Members of a group practice (except pathology and renal dialysis groups) must identify the 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 |

| Block No. | Description | Guidelines | Required (Paper) |
|-----------|--|---|------------------|
| 38 | Name and address of facility where services were rendered (if other than home or office) | <p>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.</p> <p>Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS).</p> <p>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.</p> | XIX |
| 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 |