

Rick Howard, Manager
Health Financing Operations, OMAP

Number: OMAP-IM-04-149

Authorized Signature

Issue Date: 12/30/04

Topic: Medical Benefits

Subject: Remittance Advice (RA) stuffer informing providers that CMS-1500 claims will be returned if not complete

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS Employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): DHS staff and others identified on the SPD, CAF, OMHAS and OMAP transmittal lists |

Message: Beginning next week, OMAP will include the following notice with all Remittance Advice forms (RAs). The notice:

- reminds providers to complete all critical fields of the CMS-1500, and
- informs them that, rather than being automatically entered into the system for processing, claims are screened and incomplete claims are returned to the provider for more information.

The stuffer will run for three weeks.

If you have any questions about this information, contact:

Contact(s):	Terry Layman		
Phone:	(503) 945-6501		
E-mail:		Fax:	

Important CMS-1500 Billing Reminder to Complete Critical Fields

We've recently changed our claim processing procedures to include a screening of certain critical fields on paper claims before entering them into our MMIS payment system. The screening allows us to identify incomplete claims and return them to you for completion. We will highlight your returned claim showing the incomplete field.

Reasons for Returning Claims

In the screening, our staff are checking to make sure the following fields (shaded in the sample at right) on the CMS-1500 are complete:

- 1a Insured ID Number - 8 alpha/numeric characters found in field 11 of the client's OMAP Medical Care ID
- 2 Patient's Name - enter the name as it appears on the OMAP Medical Care ID
- 24A Date of Service - list numeric dates of service, i.e., 11-01-04
- 24B Place of Service - list the 1- or 2-digit Place of Service code identifying where the service was provided
- 24D Procedures, Services or Supplies - list the 5-digit procedure code
- 24F Charges - enter the total usual and customary charge for each line item
- 24G Days or Units - always enter the correct number of days or units for this procedure
- 28* Total Charge - enter the total amount for all charges listed in field 24F
- 30* Balance Due - enter the total balance
- 33 Provider Number, Name, Address - enter your six digit OMAP billing or performing provider number **and** your address

Help us make sure your payment is correct and prompt -- check your claims for accuracy and completeness before you submit them to us.

*Many claims suspend because of math errors in fields 28, 29, and 30.

Need Help?

We have developed several booklets and training materials to help you complete claims forms. These materials can be found on our web page at: http://www.dhs.state.or.us/healthplan/tools_prov/tips/main.html

Call our Provider Relations Unit, if you have billing questions, at 1-800-336-6016.

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2

3. PATIENT'S BIRTH DATE MM DD YY M SEX F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) 1a

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)

8. PATIENT STATUS Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT! (CURRENT OR PREVIOUS) b. AUTO ACCIDENT? c. OTHER ACCIDENT?

11. INSURED'S POLICY GROUP OR FECA NUMBER

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

24	A	B	C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EMG Family Plan	RESERVED FOR LOCAL USE	
	FROM	TO									
	MM	DD	YY	MM	DD	YY					
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT! (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$ 28

29. AMOUNT PAID \$

30. BALANCE DUE \$ 30

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)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE # 33

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 888) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-00) FORM RRB-1500 APPROVED OMB-1215-0055 FORM QWCP-1500 APPROVED OMB-0720-0001 (CHAMPUS)