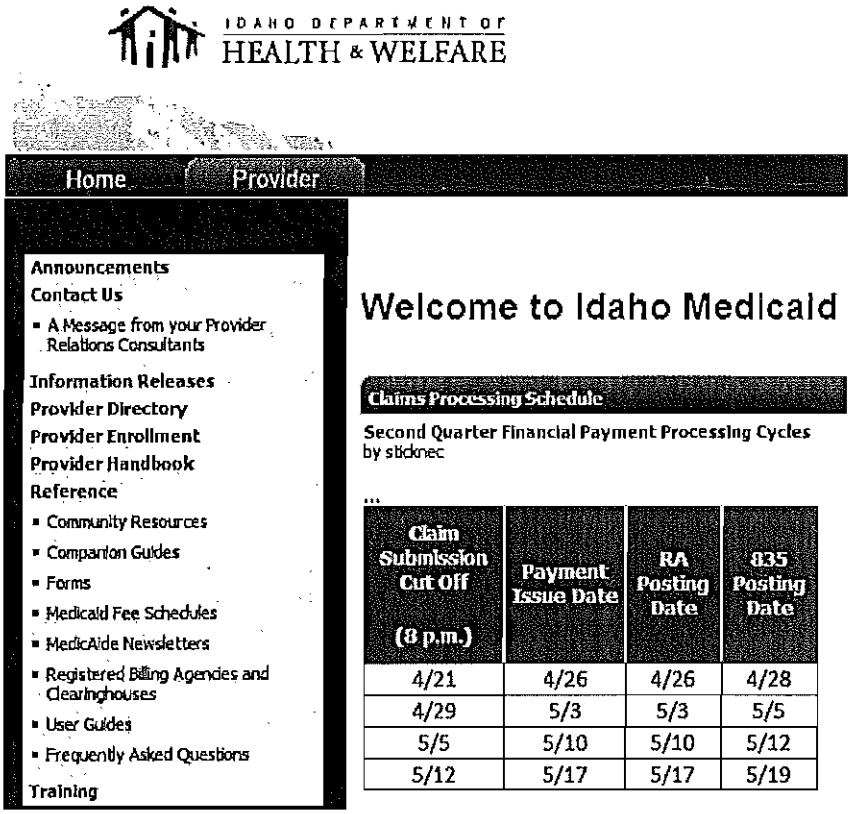
Helpful Information for Certified Family Home Providers

Certified Family Home (CFH) providers have the ability to bill claims electronically or on paper. An overview for each process are provided in this packet, as well as, links to additional information.

Information

The Idaho Medicaid web site at http://www.idmedicaid.com contains valuable information for providers.



Click on the links on the left menu to access:

- **Announcements** that are posted with information about system updates and critical information about billing.
- **Information Releases** (IR) to access all the IRs from DHW.
- **Provider Enrollment** to perform maintenance on your provider record.
- **Forms** to find all the forms you need.
- **User Guides** to find instructions
- **Frequently Asked Questions** to find out information that many providers have already asked.

Provider Handbook

These documents are located on the Web site and contain general information for all providers and specific billing information for CFH. Click on the link for **Provider Handbooks**. You will find the following documents that will be helpful to you as a CFH provider:

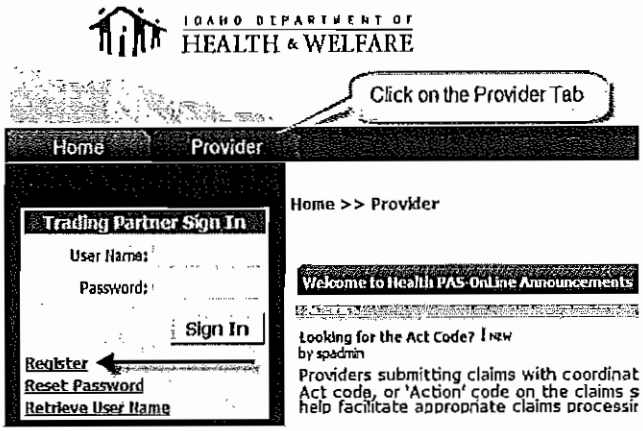
- General Information
  - Overview
  - Directory
  - General billing Instructions
  - General Provider and Participant Information
  - Remittance Advice Analysis
- Reference
  - Glossary
- Claim Form Instructions
  - CMS 1500 Instructions
- Provider Guidelines
  - Adult Residential Care, Certified Family Homes

Trading Partner Account

In order to submit claims electronically, you need to become a Trading Partner. This will allow you secure access to submit claims online and view the status of your claims.

To become registered as a trading partner you will need an e-mail address. You will also need to supply the following elements for account activation:

- Provider ID/NPI
- Tax ID (FEIN/SSN)
- PIN (Enrollment Case Number) or EFT/Check Number (from prior 90 days)



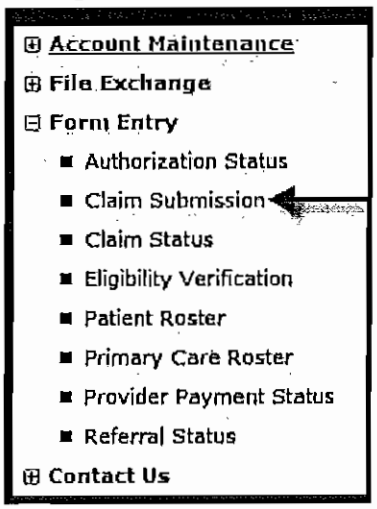
For complete instructions on registering as a Trading Partner, go to www.idmedicaid.com and click on the link for User Guides. Click on the ***TPA-Trading Partner Account Registration User Guide*** to open it. If you like, you can print a copy to refer to while you are working through the registration process.

To register on the Idaho Medicaid Web site, click on the Provider Tab. Then click on the **Register** link. Fill out the form with the required information and submit your registration. You will receive an e-mail giving you further instructions.

Billing Electronically

Once you have registered as a Trading Partner, you can sign in to your account and you will see a menu with links to different actions. Refer to the ***TPA-Trading Partner Account Getting Started Guide*** for helpful information on filling out forms, finding members, code search, and adding attachments.

To begin to submit electronic claims, you will want to refer to the ***TPA-Trading Partner Account Claim Submission Guide*** to help you with the process of submitting your claims correctly.



Once you have become familiar with how to submit claims online, you may want to check the status of a claim. The ***TPA-Trading Partner Account Claim Status Guide*** will give you instructions to check the status of a claim.

You may want to create a Patient Roster to use to submit claims and verify eligibility. Refer to the ***TPA-Trading Partner Account Patient Roster Guide*** for instructions on how to build your roster.

This guide will also explain how to copy the last claim for a participant so you do not have to complete the same information each time you need to submit a similar claim. The *Patient Identifier* and *Claim Date of Service* will not be copied over to the new screen. This must be entered for each new claim.

The next page shows the required fields and the fields that are required, but will be populated by the system. Submitting your claim online is easy and quick.

Online Claim Form

My Health PAS

You Are Here: Claim Wizard - Professional Claim

Enter information in the fields provided below and click the Submit button.

* Required Field

Claim Information

Billing Provider:

Member Name:

Patient Account #: Required

Date of Birth:

Medical Record #:

Member ID:

Referring Provider:

Rendering Provider *: Select Rendering Provider — Required, but the system populates.

Service Location: Select Service Location — Required

☐ Encounter claim

Diagnosis

NOTE: At least one Diagnosis code is required

Line #	Code	Description	Type
1			

Required. After entering, press tab.

Required, but the system will populate after you enter the code.

Services

☐ Enter NDC Codes

Line #	DOS From *	DOS To *	Place of Service *	Code *	Modifier(s)	Related Diagnosis *	Charge *	Units *	EPSDT	Emergency	Auth #	Rendering Provider
1									☐	☐		AMBROSE, M.
	Required	Required	Required	Required		Required	Required	Required				

Service Code Description:

Total: $0.00

Units: 0

Only enter a modifier if required with your procedure code.

Enter Oxygen Therapy

Enter COB Information

Additional Information

☐ Employment ☐ Auto Accident ☐ Other Accident

State:

Date of Accident: MM/DD/YYYY

Submit

Click on the **Submit** button when you have completed filling in the form.

Paper Billing

If you would prefer to submit your claims on paper, the next page shows the CMS 1500 claim form. An explanation of the fields that are necessary to be completed are described in the table that follows the claim form.

The Provider Handbook, Claim Form Instructions for the CMS 1500 has complete information for billing on the professional form. Some of the tips and instructions are included in this document.

MAIL ALL 1500 CLAIM FORMS TO:
MOLINA MEDICAID SOLUTIONS
PO BOX 70084
BOISE ID 83707

Instructions and Tips for Completing the CMS 1500

- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Enter all dates except the Patient's Birth Date using the 2-digit month, day, and year (MM/DD/YY) format.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Do not enter any data or documentation on the claim form that is not listed as required below.

Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claims will be rejected when required information is not entered into a required field. The following numbered items correspond to the CMS-1500 (08/05) claim form.

Appendix A.1.2 is for Certified Family Homes and contains specific codes that can be billed by CFH providers.

A.1.2 Certified Family Home (CFH)

HCPCS	Description
S5140	Certified Family Home –Daily one to two Participants Foster Care - Adult; per diem 1 Unit = 1 day
T1019	Personal Care service per 15 minutes
S5100	Adult Foster Care
H2011	Crisis intervention per 15 minutes

All paper claims are electronically scanned for processing. The printed versions of the claim forms are machine readable. As such, they are printed using special paper, special color inks, and within precise specifications. For this reason, only original, color forms can be used for scanning. Forms that cannot be scanned are returned to the provider.

CMS 1500 Form Descriptions

Box No.	Field Name	Notes
1A	Insured's ID	(Required) Enter the Participant's Idaho Medicaid ID number exactly as it appears on their plastic ID card
2	Patient's Name	(Required) Enter the participant's name exactly as it appears on the Participant's Idaho Medicaid ID card. Enter as last name, first name, middle initial.
3	Patient's Birth Date	(Required) Enter the patient's date of birth. Formatted as MMDDCCYY
3	Sex	(Required) Check the appropriate box indicating the patient's gender. M – Male, F - Female
5	Patient's Address	(Required) Enter Patient's Street Address
5	City	(Required) Enter the patient's city
5	State	(Required) Enter the patient's 2 character state code.

Box No.	Field Name	Notes
5	Zip	(Required) Enter patient's 5 or 9 digit zip code.
21 (1-4)	Diagnosis or Nature of Illness or Injury	(At least one Required) Enter the appropriate ICD-9-CM codes (up to 4). Enter the primary diagnosis in 21(1). If applicable, second, third, and fourth diagnosis in 21 (2-4). Always enter the entire diagnosis code including the decimal point.
22	Medicaid Resubmission Code	(Required if claim is a resubmission) Enter 7 if claim is a replacement claim. Enter 8 if this claim voids a previously submitted claim. Only enter a value in this field if sending an replacement or void to a previously submitted claim, otherwise leave blank.
22	Original REF. NO.	(Required if claim is a resubmission) Enter the claim ID number of the original claim to be voided or replaced. Only enter a value in this field if sending a replacement or void to a previously submitted claim, otherwise leave blank.
24A *	Date of Service - From/To	(Required) Enter the from and to date(s) the service was provided, using the following format: MMDDYY
24B *	Place of Service	(Required) Enter the appropriate 2 digit numeric code
24D *	Procedures, Services, or Supplies	(Required) Enter the appropriate five-character HCPCS procedure code to identify the service provided.
24D *	Modifier	(Desired) If applicable, add the appropriate HCPCS two digit modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E *	Diagnosis Code	(Required if diagnosis code in block 21 is present) Use the number of the subfield (1-4) for the diagnosis code entered in field 21. If the actual diagnosis code from block 21 is present, enter a '1'. If the pointer is missing, leave the field blank.
24F *	Charges	(Required) Enter the usual and customary fee for each line item or service. Do not include tax.
24G *	Days or Units	(Required) Enter the quantity or number of units of the service provided. Maximum value of 9999999. If there is a zero leading a value you need to remove it (IE. 01 will be 1).
25	Federal Tax ID Number	(Required) Enter the Federal Tax ID. Must be 9 numeric characters.
26	Patient Account Number	(Required) Enter patient account number.
28	Total Charge	(Required) Enter total of all service line charges
32 Line 1	Service Facility Name	(Required if diagnosis code in block 21 is present) Enter name of service facility only if Service Location is different than Billing Provider name in box 33, otherwise leave box 32 blank.
32 Line 2	Service Facility Address line 1	(Required if diagnosis code in block 21 is present) Enter Street Address of Service Facility, only if Service Location address is different than Billing Provider address in box 33, otherwise leave box 32 blank.
32 Line 3	Service Facility Address line 2	(Not Required) Enter additional service facility address line if needed and service location if different than billing provider address in box 33, otherwise leave box 32 blank.
32 Line 3 or 4	Service Facility City, State and Zip Code	(Required if diagnosis code in block 21 is present) Enter Service Facility city, state, and zip code, only if Service Location address is different than Billing Provider address in box 33, otherwise leave box 32 blank.
32a	Service Facility Location ID (NPI)	(Required, if applicable) If you bill with an NPI, enter the 14-digit service location identifier only if the services were rendered at a location other than that of the billing provider in box 33. Do not enter any other value in box 32a. For example, 1234567890-001.
32b	Service Facility Location ID (blank)	(Required, if applicable) If you bill with an Idaho proprietary number (not an NPI) enter the 12-digit service location identifier only if rendered at a location other than that of the billing provider in box 33. Do not enter any other value in box 32b. For example, M1234567-001 or A1234567-001.
33 Line 1	Billing Provider Name	(Required) Enter billing provider name
33 Line 2	Billing Provider Address line 1	(Required) Enter street address of billing provider
33 Line 3	Billing Provider Address line 2	(Not Required) Enter additional billing provider address line, if needed
33 Line 3 or 4	Billing Provider city, state, and zip code	(Required) Enter billing provider city, state, and zip code
33a	NPI Number	(Required, if billing with an NPI) Enter the 10-digit NPI number of the billing provider.
33b	Billing Provider Medicaid ID	(Required if not billing with NPI in 33a) Enter the qualifier 1D followed by the provider's 8-digit proprietary Idaho Medicaid provider number with no spaces in between.

**unshaded*

CMS 1500 Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH. # ( ) a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHOA-10-FINV / WHOA-10-FUNKS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS