Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 TDD: 501-682-6789
Internet Website: www.medicaid.state.ar.us

TO: **Arkansas Medicaid Health Care Providers**

DATE: **July 1, 2007**

SUBJECT: **Section V Provider Manual Update Transmittal**

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	56
Ambulatory Surgical Center	88
ARKids First-B	52
Certified Nurse-Midwife	84
Child Health Management Services	88
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment	90
Children's Services Targeted Case Management	39
Chiropractic	83
DDS Alternative Community Services Waiver	80
Dental	108
Developmental Day Treatment Clinic Services	93
Developmental Rehabilitation Services	39
Division of Youth Services and Division of Children and Family Services Targeted Case Management	30
Domiciliary Care	61
ElderChoices Home and Community-Based 2176 Waiver	81
Federally Qualified Health Center	77
Hearing Services	72
Home Health	98
Hospice	71
Hospital/End-Stage Renal Disease	118
Hyperalimentation	96
Inpatient Psychiatric Services for Under Age 21	88
Licensed Mental Health Practitioners	70
Living Choices Assisted Living	36
Medicare/Medicaid Crossover Only	58
Nurse Practitioner	88
Occupational, Physical, Speech Therapy Services	81

Provider Manual	Transmittal Number
Personal Care	92
Pharmacy	107
Physician/Independent Lab/CRNA/Radiation Therapy Center	135
Podiatrist	85
Portable X-Ray Services	74
Private Duty Nursing Services	80
Program of All-Inclusive Care for the Elderly (PACE)	11
Prosthetics	101
Rehabilitative Hospital	83
Rehabilitative Services for Persons with Mental Illness	80
Rehabilitative Services for Persons with Physical Disabilities	59
Rehabilitative Services for Youth and Children	35
Rural Health Clinic Services	76
School-Based Mental Health Services	45
Targeted Case Management	77
Transportation	91
Ventilator Equipment	77
Visual Care	91

Explanation of Updates

Section V has been updated

- to add the new version of the CMS-1500 (08/05)
- to add the new version of the CMS-1450 (UBO4L)
- to add the new version of the ADA Dental Claim Form ADAJ510
- to add to the type of service field on the Request for Benefits Form DMS-699 to include modifiers and to add additional claim form instructions
- to remove the reference to type of service on EPSDT Claim Form DMS-694.
- to remove the reference to type of service on Arkansas Foundation for Medical Care,Inc. Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components AFMC-103 and change the title of that field to allow space for an additional modifier.
- to add additional instructions and clarifications on the Request for Extension of Benefits For Clinical, Outpatient , Laboratory and X-Ray Services DMS-671.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

_____

Roy Jeffus, Director

Claim Forms

Red-ink Claim Forms

The following is a listing of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information on where to get the forms and links to samples of the forms are available below. To view a sample of the form click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450	Business Form Supplier
EPSDT – DMS-694**	EDS - 1-800-457-4454
Visual Care – DMS-26-V	EDS - 1-800-457-4454
Inpatient Crossover – EDS-MC-001	EDS - 1-800-457-4454
Long Term Care Crossover – EDS-MC-002	EDS - 1-800-457-4454
Outpatient Crossover – EDS-MC-003	EDS - 1-800-457-4454
Professional Crossover – EDS-MC-004	EDS - 1-800-457-4454

** A printable **PROVIDER INTEROFFICE DOCUMENTATION ONLY** version of this form is available below under Arkansas Medicaid Forms.

Claim Forms

The following is a listing of the non-red-ink claim forms required by Arkansas Medicaid. Information on where to get a supply of the forms and links to samples of the forms are available below. To view a sample of the form click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J510	Business Form Supplier
Hospice/INH Claim Form – DHS-754	EDS – 1-800-457-4454

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Number
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form - Medicaid XIX	EDS-AR-004
AFMC Personal Care Assessment and Service Plan for Medicaid Beneficiaries Under Age 21	AFMC-201

Form Name	Form Number
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	AFMC-103
AFMC Request For Bilaminate Skin Substitutes	AFMC-RBSS
Amplification/Assistive Technology Recommendation Form	DMS-686
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Assisted Living Waiver Plan of Care	AAS-9565
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need - Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	AFMC-102
CHMS Request for Prior Authorization	AFMC-101
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Claim Form — You may print this version for use in charts and electronic billing documentation; however, if you submit a paper claim for billing, you must use the red-ink version (see Red-ink Claim Forms above.)	EPSDT-DMS-694
EPSDT Provider Agreement	DMS-831
Evaluation Form Lower-Limb	DMS-646
Explanation of Check Refund	EDS-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645

Form Name	Form Number
Individual Renewal Form for DDTCS Therapists & School Based Therapists	DMS-0663
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	None
Medicaid Claim Inquiry Form	EDS-CI-003
Medicaid Form Request	EDS-MFR-001
Medical Assistance Dental Disposition	DMS-2635
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Personal Care Assessment and Service Plan	DMS-618
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Prescription Drug Prior Authorization and Extension of Benefits Request Form	DMS-2694
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Prosthetic-Orthotic Lower-Limb Amputee Evaluation	DMS-650
Prosthetic-Orthotic Upper-Limb Amputee Evaluation	DMS-648
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Enrollment Application and Contract Package	AppMaterial
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request For Orthodontic Treatment	DMS-32-0

Form Name	Form Number
Request for Private Duty Nursing Services Prior Authorization and Prescription - Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form - Information for Men	PUB-020
Sterilization Consent Form - Information for Women	PUB-019
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	None
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9565
Address Change
AFMC-101
AFMC-102
AFMC-103
AFMC-201
AFMC-RBSS
Authorization for Automatic Deposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0663
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2694
DMS-2698
DMS-32-A
DMS-32-O
DMS-601
DMS-602
DMS-612
DMS-615
DMS-616
DMS-618
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-646
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-653
DMS-671
DMS-673
DMS-679
DMS-683
DMS-686
DMS-693
DMS-694 chart version
DMS-694 sample
DMS-699
DMS-831
ECSE-R
EDS-AR-004
EDS-CI-003
EDS-CR-002
EDS-MFR-001
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

- American Hospital Association
- Americans with Disabilities Act Coordinator
- APS Healthcare Midwest (APS)
- Arkansas Department of Education, Health and Nursing Services Specialist
- Arkansas Department of Education, Special Education
- Arkansas DHHS Division of Human Services - Aging and Adult Services
- Arkansas DHHS Division of Human Services – Appeals and Hearings Section
- Arkansas DHHS Division of Human Services, Child Care and Early Childhood Education, Child Care Licensing Unit
- Arkansas DHHS Division of Human Services, Children and Family Services, Contracts Management Unit
- Arkansas DHHS Division of Human Services, Children's Services
- Arkansas DHHS Division of Human Services, County Operations - Customer Assistance Section
- Arkansas DHHS Division of Human Services, Medical Services
- Arkansas DHHS Division of Human Services, Medical Services Dental Care Unit
- Arkansas DHHS Division of Human Services, Medical Services Director
- Arkansas DHHS Division of Human Services, Medical Services Financial Activities Unit
- Arkansas DHHS Division of Human Services, Medical Services Hearing Aid Consultant
- Arkansas DHHS Division of Human Services, Medical Services Medical Assistance Unit
- Arkansas DHHS Division of Human Services, Medical Services Pharmacy Unit-Utilization Review Section
- Arkansas DHHS Division of Human Services, Medical Services Program Communications Unit
- Arkansas DHHS Division of Human Services, Medical Services Third-Party Liability Unit
- Arkansas DHHS Division of Human Services, Medical Services UR Benefit Extension Requests Section
- Arkansas DHHS Division of Human Services, Medical Services UR/Home Health Extensions
- Arkansas DHHS Division of Human Services, Medical Services Utilization Review Section
- Arkansas DHHS Division of Human Services, Medical Services Visual Care Coordinator
- Arkansas DHHS Division of Human Services, Medical Services, Provider Reimbursement Unit
- Arkansas DHHS, Division of Health

ADA Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination /Preauthorization

☐ EPSDT /Title XIX

2 Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13 Date of Birth (MM/DD/CCYY)	14 Gender ☐ M ☐ F	15 Policyholder/Subscriber ID (SSN or ID#)

16 Plan/Group Number	17 Employer Name

OTHER COVERAGE

4 Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)	7 Gender ☐ M ☐ F	8 Policyholder/Subscriber ID (SSN or ID#)

9 Plan/Group Number	10 Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18 Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19 Student Status ☐ FTS ☐ PTS

20 Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21 Date of Birth (MM/DD/CCYY)	22 Gender ☐ M ☐ F	23 Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	30 Description	31 Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34 (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32 Other Fee(s)

33 Total Fee

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____

Patient/Guardian signature Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named dentist or dental entity.

X _____

Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39 Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40 Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44 Date Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto Accident ☐ Other Accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48 Name, Address, City, State, Zip Code

49 NPI	50 License Number	51 SSN or TIN

52 Phone Number ( ) -	52A Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____

Signed (Treating Dentist) Date

54 NPI	55 License Number

56 Address, City, State, Zip Code	56A Provider Specialty Code

57 Phone Number ( ) -	58 Additional Provider ID

Request for Extension of Benefits

Provider
Address
Address

City _____ State _____ Zip Code _____

Patient's Name _____

Address _____

City _____ State _____ Zip Code _____

Medicaid ID Number _____ Birthdate _____ Sex _____

Diagnoses _____

Benefit Extensions Requested

Procedure Code	Type of Service Code or Modifiers After 07/01/07	Service From Date	Service To Date	Units

Attach a summary and medical records as needed to justify medical necessity.

Provider ID Number/Taxonomy Code _____

Provider's Signature _____ Date _____

Request Disposition

(To be completed by reviewer)

Approved _____ Denied _____ Control Number _____

Procedure Code	Type of Service Code	Service From Date	Service To Date	Units

Instructions for Completion of Request for Extension of Benefits – DMS-699 (Rev.4/07)

ALL REQUIRED FIELDS OF FORM DMS-699 MUST BE CORRECTLY COMPLETED BY ENTERING THE FOLLOWING INFORMATION

Enter Provider Name, Address, City, State, Zip Code – **REQUIRED**

Enter Patient's Full Name – **REQUIRED**

Enter Patient's Address, City, State, Zip Code – If Available

Enter Patient's Arkansas Medicaid ID Number, Birth Date, and Sex – **REQUIRED**

Enter Diagnoses -Primary to Request First- Then Additional if Applicable – **REQUIRED**

Enter Correct Medicaid Procedure Code for Items Requested for Extension – **REQUIRED**

Enter Correct "Type of Service Code" or **All Applicable Modifiers (After 07/01/07)** – **REQUIRED**

Enter From Date of Service – **REQUIRED**

Enter To Date of Service – **REQUIRED**

Enter Correct Number of Units Being Requested – **REQUIRED**

Enter Provider ID Number – **REQUIRED**

Enter Provider Taxonomy Code - if Applicable

Complete with an Original Signature by Provider or Provider's Authorized Representative -**REQUIRED**

ATTACH A SUMMARY AND MEDICAL RECORDS AS NEEDED TO JUSTIFY MEDICAL NECESSITY – **REQUIRED**

COUNTY OFFICE

EPSDT

Provider Inter-office Use
Patient Charting and Electronic Billing Documention Version Only
This Copy Not To Be Used For Paper Claim Billing

Section I - Patient Identification

PATIENT'S LAST NAME (1)	FIRST (2)	MI (3)	SEX (4) ☐ M ☐ F	PATIENT'S MEDICAID ID NO. (5)

CASEHEAD'S NAME (6)	COUNTY OF RESIDENCE (7)	DATE OF BIRTH (8) MO DAY YEAR	STREET ADDRESS (9)	CITY (10)

IF PATIENT IS A REFERRAL (11) ENTER NAME OF REFERRING PHYSICIAN / PROVIDER ID NUMBER/TAXONOMY CODE	MEDICAL RECORD NUMBER (12)	PROVIDER PHONE NUMBER PAY TO: PROVIDER NAME AND ADDRESS (13)

OTHER HEALTH INSURANCE COVERAGE (14) (ENTER NAME OF PLAN AND POLICY NUMBER.)	WAS CONDITION RELATED TO: (15) A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN ACCIDENT ☐ YES ☐ NO	PAY TO PROVIDER ID NUMBER/TAXONOMY CODE

PRIMARY DIAGNOSIS OR NATURE OF INJURY (16)	DIAGNOSIS CODE	TYPE OF SCREEN (18) PERIODIC _____ INTER-PERIODIC _____

Section II - Examination Report (20)

Type of Test or Examination

		NORMAL	ABNORMAL	COUNSELED	TREATED	REFERRED
A. Basic Screening—						
1. Growth and Nutrition	(A)					
2. Development Assessment	(B)					
3. Unclothed Physical	(C)					
a. Neurological Exam	(D)					
b. Cardiac Status	(E)					
4. Vision	(F)					
5. Hearing	(G)					
6. Teeth (Children under 3 years)	(H)					
7. Lab Tests (Appropriate for age and population group)	(I)					
a. Hematologic	(J)					
b. Urinalysis	(K)					
c. Lead Level Screen	(L)					
d. Other (Specify)	(M)					
B. Immunization Status	(N)					
C. Other (Specify)	(Z)					

COMMENTS (21)

(22) A DATE OF SERVICE FROM TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G. PERFORMING PROVIDER ID NUMBER/ TAXONOMY CODE

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements of documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws. No additional charges for compensable services will be made against anyone; payment will be accepted as payment in **FULL,** that the above services claimed for payment have been completed and that the above services have been furnished in full compliance (without discrimination) within the provisions of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

(26) PROVIDER'S SIGNATURE _____ BILLING DATE (27)

(23) **TOTAL CHARGES**	
(24) **COVERED BY INSURANCE**	
(25) **BALANCE DUE**	

FOR OFFICE USE (28)

DMS-694 (Rev. 7/07)

Instructions for Completion of the EPSDT Claim Form – DMS-694

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those which require attachments or manual pricing.

To bill for a Child Health Services (EPSDT) screening service, use the claim form DMS-694. The numbered items correspond to numbered fields on the claim form. The DMS-694 is used as a combined referral, screening results document and a billing form. Each screening should be billed separately, providing the appropriate information for each of the screening components. The following numbered items correspond to numbered fields on the claim form.

Medical services such as immunizations and laboratory procedures may also be billed on the DMS-694 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print the EDS Claims Department contact information.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

Field Name and Number	Instructions for Completion
1. Patient's Last Name	Enter the patient's last name.
2. Patient's First Name	Enter patient's first name.
3. Patient's Middle Initial	Enter patient's middle initial.
4. Patient's Sex	Check "M" for male or "F" for female.
5. Patient's Medicaid ID No.	Enter the entire 10-digit patient Medicaid identification number.
6. Casehead's Name	Enter the casehead name for TEA children only. Patient's name has been requested in Blocks 1, 2 and 3.
7. County of Residence	Enter the patient's county of residence.
8. Date of Birth	Enter the patient's date of birth in month and year format as it appears on the Medicaid identification card.
9. Street Address	Enter the patient's street address.
10. City	Enter the patient's city of residence.
11. If a Patient is a Referral Enter Name of Referring Physician Provider Identification Number/Taxonomy Code	If the patient is a referral, enter the name of the referring physician and his or her provider identification number and taxonomy code.
12. Medical Record Number	This is an optional entry that the provider may use for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alpha characters will be accepted. This number will appear on the Remittance Advice (RA) and is a method of identifying payment of the claim.

Field Name and Number	Instructions for Completion
13. Provider Phone Number Pay To: Provider Name and Address Pay To: Provider Number	Enter the provider's complete name, address, provider identification number, and taxonomy code. If a clinic billing is involved, use the clinic provider identification number. Telephone number is requested but not required.
14. Other Health Insurance Coverage (Enter Name of Plan and Policy Number)	If applicable, enter the name of the insurance plan and the policy number of any health insurance coverage carried by the patient other than Medicaid. The patient's Medicaid identification card should indicate "Yes" if other coverage is carried by the beneficiary.
15. Was Condition Related to:	
A. Patient's Employment	Check "Yes" if the patient's condition was employment related. If the condition was not employment related, check "No."
B. An Accident	Check "Yes" if the patient's condition was related to an accident. Check "No" if the condition was not accident related.
16. Primary Diagnosis or Nature of Injury	Enter the description of the primary reason for treatment of the patient.
Diagnosis Code	Enter the ICD-9-CM Code that identifies the primary diagnosis.
18. Type of Screen Periodic Interperiodic	Not required for Medicaid. Completed by Human Services, if applicable.
SECTION II	
20. Examination Report	To be completed by screening provider at time of screen.
A. Basic Screening	
Item A, Numbers 1 through 6	Check "Normal" or "Abnormal" for each component. Check "Counseled," "Treated" or "Referred" as applicable.
Item A, Number 7	Give results of the lab tests performed at the time of screen.
Item B	Immunization status appropriate for age and health history. If immunization cannot be performed, note the reason along with the return appointment in "Comments" section.
Item C	Enter any other services rendered.
21. Comments	Briefly explain any problems identified and describe treatment or referral. If referred, indicate the name of the provider to whom the referral was made.
22. A. Date of Service	Enter the "from" and "to" dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.

Field Name and Number	Instructions for Completion
C. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given *(Explain Unusual Services or Circumstances)* Procedure Code (Identify)	Enter the appropriate HCPCS, CPT and state assigned procedure code and describe any services or circumstances, e.g., what age periodicity screen has been provided and describe procedures performed (including screen, lab test, immunizations, etc.).
D. Diagnosis Code	Enter the ICD-9-CM code, which corresponds with the procedures performed.
E. Charges	Enter the charges for the rendered services. These charges should be the provider's current usual and customary fee to private clients.
F. Days or Units	Enter days or units of service rendered.
G. Performing Provider Number	If the billing provider noted in Block 13 is a clinic or group, enter the attending provider's provider identification number and taxonomy code.
23. Total Charges	Enter the total of Column 22E. This block should contain a sum of charges for all services indicated on the claim form.
24. Covered by Insurance	Enter the total amount of funds received from other sources. The source of payment should be indicated in Block 14. If payment was received from the patient, indicate in Block 14, but DO NOT include the amount in Block 24.
25. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.
26. Provider's Signature	The provider or designated authorized individual must sign the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
27. Billing Date	Enter date signed.