ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecV-4-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
AAS-9559	02/2004	AAS-9559	10/2012

Explanation of Updates

The Alternatives Attendant Care Provider Claim Form AAS-9559 has been reformatted as a Microsoft Word document and information on the form has been updated.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 3-4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

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Andrew Allison, PhD
Director

Alternatives Attendant Care Provider Claim Form

☐	Medicare	☐	Medicaid	☐	CHAMPUS	☐	CAMPVA	☐	Group Health Plan	☐	FECA ☐ Other BLK LUNG
☐ Medicare #	☒ Medicaid #	☐ Sponsor's SSN	☐ VA File #	SSN or ID	☐ SSN	☐ ID					

MEDICAID NUMBER

PATIENT'S NAME (Last name, First name, Middle Initial)	**PATIENT'S BIRTHDATE**	**GENDER**
ADDRESS	**Patient Relationship to Insured** ☒ Self ☐ Spouse ☐ Child ☐ Other	
CITY / **STATE**	**Patient Status** ☐ Single ☐ Married ☐ Other	
ZIP CODE / **TELEPHONE #**		**Full Time** ☐ **Part Time** ☐

FOR BILLING OFFICE USE ONLY
Procedure Code: **S5125**
Type of Service Code: **9**
Diagnosis Code:

CLIENT OR AUTHORIZED PERSON'S SIGNATURE (Must be Signed)

I authorize the release of any medical or other information necessary to request payment of government benefits either to myself or to the party who accepts the assignment. I authorize payment of medical benefits to the undersigned. I certify that my attendant caregiver furnished the attendant care services* in accordance with my plan of care and specific directions, and that the services were satisfactory.

SIGNED		**DATE**	

ATTENDANT CARE BILLING

DATES OF SERVICE		**TIME IN**	**TIME OUT**	**HOURS WORKED**	**UNITS WORKED (HOURS X 4)**	**BILLING AMOUNT (UNITS X $2.43)**
DATE	**DAY OF WEEK**					
			TOTALS			

PROVIDER INFORMATION

NAME:	**PIN #:**	**SSN#:**
ADDRESS:		
PHONE #:		

Provider Signature	**Date**

*Attendant Care Services, Procedure Code S5125, is defined as: assistance to a participant who is medically stable and has a physical disability in accomplishing tasks of daily living that the participant is unable to complete independently. Assistance may vary from actually doing a task for the participant, to assisting the participant to perform the task or to providing safety support while the participant performs the task. Tasks may include the following: Feeding Assistance; Encourage Fluids; Grooming/Oral Care; Bathing; Shampoo; Mobility/Transfer Assistance; Shave; Supervise/Assist with Ambulation; Skin Care; Range of Motion Exercise; Toileting; Meal Preparation; Housekeeping; Laundry; Shopping/Errands/Transportation. Refer to Medicaid Policy Section II for additional information regarding Attendant Care Services and the associated tasks.

Mail Claim Form to:
HP, Alternatives Claims
PO Box 709
Little Rock, AR 72203
1 (800) 457-4454