



Iowa Department of Human Services

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For Human Services use only:

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ALL PROVIDERS MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **ALL PROVIDERS MANUAL**, Chapter IV, *Billing Iowa Medicaid*, Contents (page 1), revised; and pages 1 through 4, 17, 19, 43, 44, 56, 61, 65, 71 through 76, and 85, revised.

Summary

ALL PROVIDERS MANUAL, Chapter IV. *Billing Iowa Medicaid*, is revised to:

- ◆ Align with current IA Health Link policies, procedures, and terminology.
- ◆ Align with current ICD-10 policies, procedures, and terminology.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages in the **ALL PROVIDERS MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter IV	
Contents (page 1)	January 1, 2015
1-4, 17, 19, 43, 44, 56, 61	January 1, 2015
65, 71-76, 85	October 1, 2013

Additional Information

The updated provider manual containing the revised pages can be found at:

<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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Preamble

This provider manual is intended to provide general coverage guidelines for members that are currently Medicaid Fee-for-Service (FFS) eligible. Verifying a member's eligibility is crucial to ensure correct coverage of services and limitations. Once an assignment to the IA Health Link Managed Care Organization (MCO) has been completed, please refer to the provider manual for the IA Health Link MCO assigned.

CHAPTER IV. BILLING IOWA MEDICAID

A. INTRODUCTION

The Iowa Medicaid Billing Manual is a comprehensive explanation of billing instructions for each type of claim form used by the Iowa Medicaid Enterprise (IME). This chapter offers step-by-step instructions on claim form completion, remittance advice guides, and other supplemental information to allow for faster and more accurate claims adjudication.

The IME used the following claim forms:

- ◆ [UB-04 Claim Form](#)
- ◆ [CMS-1500 Claim Form](#)
- ◆ [American Dental Association \(ADA\) 2012 Claim](#)
- ◆ [Medicare Crossover Invoice](#)
- ◆ [Claim for Targeted Medical Care Claim Form](#)

B. TIMELY FILING REQUIREMENTS

The Iowa Medicaid Enterprise (IME) policy on timely filing requirements for resubmitting a claim for payment is as follows:

- ◆ Providers have 365 days from the date of service to submit a claim.
- ◆ A claim may be resubmitted or adjusted if it is submitted within 365 days from the last date of adjudication.
- ◆ No claim will be paid past two years from the date of service.



A copy of the Medicaid remittance advice is not required to show an original claim submission. The IME will research to verify that the original claim was received within the original submission guidelines. The resubmitted claim must be received at the IME within 365 days of the Medicaid remittance advice date of denial. If the claim is submitted within that year and denies for a second time, providers have up to one year from the date of the last adjudication to make corrections, not exceeding the two years from the date of service. As of January 1, 2009, Iowa Medicaid providers may resubmit claims electronically since remittance advices to prove the original filing dates are no longer required.

Claims should not be sent to the Department of Human Services. This will delay the processing of these claims. Resubmitted claims for services past 365 days from the last date of service should be sent to the regular IME claims address (listed below) and will be processed according to the timeline described above.

Two exceptions exist to the 365-day timely filing guideline: retroactive eligibility and third-party related delays. Each of these must be billed on paper with the proper attachment.

1. Paper Claims Addresses

a. Regular Claims, Resubmissions, and Third-Party Related Delays

Third-party related delays must be accompanied by a copy of the TPL explanation of benefits and must be received at the IME within 365 days of the TPL process date.

Medicaid Claims
PO Box 150001
Des Moines, IA 50315

b. Exception to Policy Claims (PAPER CLAIMS) and Retroactive Eligibility Claims

Retroactive eligibility claims must be accompanied by the DHS *Notice of Decision* and must be received at the IME within 365 days of the notice date.

Iowa Medicaid
Attn: Exception Processing
1305 East Walnut Street, Room 112
Des Moines, IA 50319-0112

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c. Exception to Policy Claims (ELECTRONIC CLAIMS)

Providers can now submit claims electronically for services approved under an Exception to Policy. To do so, these directions must be followed:

- ◆ When completing the claim form, enter the Exception to Policy number in the Attachment Control Number (ACN) field. The ETP number is located near the top of the ETP letter from DHS. When completing the ACN field the ETP number must be preceded with the letters "ETP." Example: 08-E1234 would be entered as ETP08-E1234. Failure to enter this number exactly may result in the claim denial. The ACN field is loop 2300 segment PWK05-06.
 - If using software other than PC-ACE Pro32, please contact your software vendor to determine where to complete the ACN field.
 - If using PC-ACE Pro 32, the ACN box is located on the Institutional claim on the Extended General tab and for the Professional claim use the EXT Pat/Gen (2) tab. For both claim form types put the ETP number in the box marked 'Attachment Control Number'. Use the drop down boxes to complete both the Type and Trans boxes.
- ◆ If the approved Exception to Policy letter states that additional attachments are required with the claim, these attachments must be faxed to (515) 725-1318. Additional attachments will be itemized in the ETP letter. The ETP letter is not considered an additional attachment and does not need to be faxed to the IME. Attachments that cannot be faxed will require that the claim be submitted on paper according to [Informational Letter 637](#).

The faxed documentation must include the *Claim Attachment Control*, form 470-3969, as the first page of documentation after the fax cover sheet. The Attachment Control Number must be the letters "ETP" plus the Exception to Policy number and must match the ACN that was entered on the claim. Failure to do so will result in the claim denying for lack of required documentation. To view a sample of the *Claim Attachment Control*, form 470-3969, click [here](#).

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2. Electronic Billing

Providers that wish to begin electronic filing can contact EDISS at <http://www.edissweb.com/med/index.html> or email support@edissweb.com. Electronic claims submission is a much cleaner and faster method to bill claims.

C. INSTRUCTIONS FOR COMPLETING THE UB-04 CLAIM FORM

The following Iowa Medicaid provider types bill for services on the UB-04 claim form:

- ◆ Hospitals
- ◆ Rehabilitation agencies
- ◆ Home health
- ◆ Skilled nursing facilities
- ◆ Hospice
- ◆ Psychiatric medical institution for children
- ◆ Nursing facilities for the mentally ill
- ◆ Mental health institutes
- ◆ Nursing facilities
- ◆ Residential facilities

To view a sample of the UB-04 claim form on line, click [here](#).

The table below contains information that will aid in the completion of the UB-04 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

The IME provides software for electronic claims submission at no charge. For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions. For assistance with setting up or questions related to electronic billing, contact EDI Support Services at (800) 967-7902, email support@edissweb.com, or visit <http://www.edissweb.com/med/>.



Field No.	Field Name/Description	Requirements	Instructions
59	Patient's Relationship to Insured	OPTIONAL	No entry required.
60 A-C	Insured's Unique ID	REQUIRED	Enter the member's Medicaid identification number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A. Enter the Medicaid ID on the line (A, B, or C) that corresponds to Medicaid from field 50 .
61	Group Name	OPTIONAL	No entry required.
62 A-C	Insurance Group Number	OPTIONAL	No entry required.
63	Treatment Authorization Codes	<i>SITUATIONAL</i>	Enter prior authorization number if applicable. NOTE: <i>This field is no longer used to report the MediPASS referral. Refer to field 79 to enter the MediPASS referral.</i> NOTE: <i>Lock-in moved to field 78.</i>
64	Document Control Number (DCN)	OPTIONAL	No entry required.
65	Employer Name	OPTIONAL	No entry required.
66	Diagnosis and Procedure code Qualifier (ICD Version Indicator)	REQUIRED	Enter the appropriate diagnosis and procedure code qualifier: For ICD-9 enter "9." For ICD-10 enter "0."



Field No.	Field Name/ Description	Requirements	Instructions
73	Untitled	OPTIONAL	No entry required.
74	Principal Procedure Code and Date	<i>SITUATIONAL</i>	REQUIRED for the principal surgical procedure. Enter the appropriate ICD-CM procedure code and surgery date, when applicable.
74 a-e	Other Procedure Codes and Dates	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedures. Enter the appropriate ICD-CM procedure codes and surgery dates.
75	Untitled	OPTIONAL	No entry required.
<i>Attending Provider Name and Identifiers</i>			
76 *	NPI	REQUIRED	Enter the NPI of the attending physician. REQUIRED when claim/encounter contains any services other than nonscheduled transportation services. <i>The attending provider is the individual who has overall responsibility for the member's medical care and treatment reported in this claim/ encounter. If not required, do not send.</i>
	Qual	LEAVE BLANK	This field must be left blank . Entering information in this field will cause the claim to be returned.
	Last	REQUIRED	Enter the last name of the referring physician.
	First	REQUIRED	Enter the first name of the referring physician.



Field No.	Field Name/Description	Requirements	Instructions
20	Outside Lab	OPTIONAL	No entry required.
21	Diagnosis or Nature of Illness or Injury and ICD Indicator	REQUIRED	<p>Indicate the applicable ICD-CM diagnosis codes in order of importance (A-primary; B-secondary; C-tertiary; D – quaternary) to a maximum of twelve diagnoses.</p> <p>If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows:</p> <p>ICD-9-CM: 640.00 through 648.93; 670.00 through 676.93; V22.0; V23.9</p> <p>ICD-10-CM: Any diagnosis code to indicate pregnancy. Example: Z33.1</p> <p>Indicate a 9 for the ICD Ind. when submitting ICD-9-CM diagnosis codes. Indicate a 0 for the ICD Ind. when submitting ICD-10-CM.</p>
22	Resubmission Code	OPTIONAL	No entry required.
23	Prior Authorization Number	<i>SITUATIONAL</i>	REQUIRED if there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.
24A Top Shaded Portion	Date(s) of Service/NDC	<i>SITUATIONAL</i>	<p>REQUIRED for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs).</p> <p>No spaces or symbols should be used in reporting this information.</p>
24A Lower Portion	Date(s) of Service	REQUIRED	<p>Enter month, day, and year under both the From and To categories for each procedure, service, or supply.</p> <p>Entry should be made in MM/DD/YY format.</p>



Field No.	Field Name/Description	Requirements	Instructions
24B	Place of Service	REQUIRED	<p>Using the chart below, enter the number corresponding to the place service was provide. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/ intellectually disabled 55 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility



Field No.	Field Name/Description	Requirements	Instructions
34	Diagnosis Code List Qualifier	<i>SITUATIONAL</i>	REQUIRED if a diagnosis code is entered in field 29a. Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes. For ICD-9 enter "B." For ICD-10 enter "AB."
34a	Diagnosis Code(s)	<i>SITUATIONAL</i>	Only REQUIRED if the member is pregnant at the time of service or received preventive services due to a physical or mental condition that impairs their ability to maintain adequate oral hygiene. If the member is pregnant, enter ICD-9 diagnosis code "V22.2" or any ICD-10 diagnosis code indicating pregnancy, e.g., "Z33.1." This will indicate that the member is pregnant and exempt from the copay requirement. If the member is disabled, enter ICD-9 diagnosis code "V49.89" or ICD-10 diagnosis code "Z78.9" or "Z74.09." This will allow for reimbursement of preventive services otherwise limited. Do not enter descriptions.
35	Remarks	<i>SITUATIONAL</i>	Enter the reason for replacement if crowns, partial or complete dentures are being replaced. Enter a brief description if treatment is the result of an occupational illness or injury, auto accident or other accident. NOTE: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information believed necessary to process the claim. Remarks should be concise and pertinent to the claim submission. Pregnancy is now indicated in field 34a.



F. INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID LONG TERM CARE CLAIM FORM

Iowa Medicaid enrolled nursing facilities and residential care facilities bill for services electronically as an institutional claim on a monthly basis. The IME offers free electronic billing software; PC-ACE Pro 32, available through <http://edissweb.com/med/index.html>. Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

G. INSTRUCTIONS FOR SUBMITTING MEDICARE CROSSOVER INVOICES

All providers enrolled with the IME are required to use a *Medicare Crossover Invoice* and attach a copy of the Medicare Explanation of Benefits (EOMB) when it is necessary to send a paper crossover billing to the IME. This requirement is pursuant to 441 Iowa Administrative Code (IAC) 80.2(2)“h.”

There are two different crossover invoice forms depending on which provider and claim types you use to bill Medicare:

- ◆ The *Medicare Crossover Invoice (Professional)*, form 470-4708. Click [here](#) to view the form online.
- ◆ The *Medicare Crossover Invoice (Institutional)*, form 470-4707. Click [here](#) to view the form online.

Submit these forms only after Medicare has paid and established a coinsurance or deductible. These forms are not for submission of a claim where Medicare has denied the charges. Continue to attach the denied EOMB from Medicare to the CMS-1500 and UB-04 claim forms when submitting for denied or non-covered charges.



Field No.	Field Name/Description	Requirements	Instructions
<i>Diagnosis or Nature of Injury or Illness</i>			
15	ICD Ver Ind	REQUIRED	Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes. For ICD-9 enter "9." For ICD-10 enter "0."
16	Prim Diag Code	REQUIRED	Indicate the applicable primary ICD-CM diagnosis code (without a decimal point).
17	Other Diag	<i>SITUATIONAL</i>	REQUIRED if there is an additional diagnosis code. Enter the ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
18	Other Diag	<i>SITUATIONAL</i>	REQUIRED if there is an additional diagnosis code. Enter the ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
<i>Service Information Transferred From Medicare Explanation of Benefits</i>			
19	From Date	REQUIRED	Enter the "From" date of service from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format.
20	To Date	REQUIRED	Enter the "To" date of service from the Medicare Explanation of Benefits. Entries should be made in a MM/DD/YY format.



Field No.	Field Name/Description	Requirements	Instructions
9	Billing Provider Zip	REQUIRED	Enter the zip code associated with the billing provider's address.
10	Taxonomy Code	REQUIRED	Enter the taxonomy code associated with the billing provider.
11	Attending Phys NPI	OPTIONAL	Enter the NPI associated with the attending provider.
12	Referring Phys NPI	OPTIONAL	Enter the NPI associated with the referring provider.
<i>Other Health Insurance Information</i>			
13	Did the Other Insurance/ TPL Deny Coverage	<i>SITUATIONAL</i>	REQUIRED if the member has insurance other than Medicare and Medicaid that has denied payment. Check if the member's other insurance has denied payment. If no, leave blank.
14	Other Insurance/ TPL Amount Paid	<i>SITUATIONAL</i>	REQUIRED if the member has insurance other than Medicare and Medicaid that has made a payment. Enter only the total amount paid by a third party. If none, leave blank. Member copayments, Medicare payments or previous Medicaid payments are not to be listed in this field.
<i>Diagnosis or Nature of Injury or Illness</i>			
15	ICD Ver Ind	REQUIRED	Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes. For ICD-9 enter "9." For ICD-10 enter "0."
16	Diag Code	REQUIRED	Indicate the applicable primary ICD-CM diagnosis code (without a decimal point).



Field No.	Field Name/Description	Requirements	Instructions
17	Other Diag Code	<i>SITUATIONAL</i>	REQUIRED if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
18	Other Diag Code	<i>SITUATIONAL</i>	REQUIRED if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
19	Other Diag Code	<i>SITUATIONAL</i>	REQUIRED if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
20	Other Diag Code	<i>SITUATIONAL</i>	REQUIRED if there is an additional diagnosis code. Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
21	Proc Code	<i>SITUATIONAL</i>	REQUIRED for the principal surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
21A	Date	<i>SITUATIONAL</i>	REQUIRED if there is an ICD-CM principal surgical procedure code entered in field 21, enter the date associated with the principal surgical procedure code.
22	Other Proc Code	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.



Field No.	Field Name/Description	Requirements	Instructions
22A	Date	<i>SITUATIONAL</i>	REQUIRED if there is an ICD-CM additional surgical procedure code entered in field 22, enter the date associated with the additional surgical procedure code.
23	Other Proc Code	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
23A	Date	<i>SITUATIONAL</i>	REQUIRED if there is an ICD-CM additional surgical procedure code entered in field 23, enter the date associated with the additional surgical procedure code.
24	Other Proc Code	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
24A	Date	<i>SITUATIONAL</i>	REQUIRED if there is an ICD-CM additional surgical procedure code entered in field 24, enter the date associated with the additional surgical procedure code.
25	Other Proc Code	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
25A	Date	<i>SITUATIONAL</i>	REQUIRED if there is an ICD-CM additional surgical procedure code entered in field 25, enter the date associated with the additional surgical procedure code.
26	Other Proc Code	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.



Field No.	Field Name/Description	Requirements	Instructions
26A	Date	<i>SITUATIONAL</i>	REQUIRED if there is an ICD-CM additional surgical procedure code entered in field 26, enter the date associated with the additional surgical procedure code.
<i>Service Information Transferred From Medicare Explanation of Benefits</i>			
27	Covered Days	<i>SITUATIONAL</i>	REQUIRED FOR NURSING FACILITIES Enter the number of covered days. Do not use the day of discharge in your calculations.
28	TOB	REQUIRED	Enter a three-digit type of bill consisting of one digit from each of the following categories in this sequence: First digit: Type of facility Second digit: Bill classification Third digit: Frequency Type of Facility 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice Bill Classification 1 Inpatient hospital, inpatient skilled nursing facility or hospice (nonhospital-based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient skilled nursing facility or hospice (hospital-based) 4 Hospital-referenced laboratory services, home health agency, rehabilitation agency



Field No.	Field Name/Description	Requirements	Instructions
			<p>Frequency</p> <ol style="list-style-type: none"> 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
29	From Date	REQUIRED	<p>Enter the “From” date of service from the Medicare Explanation of Benefits.</p> <p>Entries should be made in a MM/DD/YY format.</p>
30	To Date	REQUIRED	<p>Enter the “To” date of service from the Medicare Explanation of Benefits.</p> <p>Entries should be made in a MM/DD/YY format.</p>
31	Covered Chgs	REQUIRED	<p>Enter the total covered charges from the Medicare Explanation of Benefits.</p>
32	Non-Cov Chgs	<i>SITUATIONAL</i>	<p>REQUIRED if there are total non-covered charges indicated on the Medicare Explanation of Benefits.</p> <p>Enter the total non-covered charges from the Medicare Explanation of Benefits.</p>
33	Blood Deduct	<i>SITUATIONAL</i>	<p>REQUIRED if there is a blood deductible amount indicated on the Medicare Explanation of Benefits.</p> <p>Enter the total blood deductible amount from the Medicare Explanation of Benefits.</p>
34	Reserved	LEAVE BLANK	<p>This field must be left blank.</p>
35	Deductible	<i>SITUATIONAL</i>	<p>REQUIRED if there is a deductible amount indicated on the Medicare Explanation of Benefits.</p> <p>Enter the total deductible amount from the Medicare Explanation of Benefits.</p>



Field No.	Field Name/Description	Requirements	Instructions
36	Coinsurance	<i>SITUATIONAL</i>	REQUIRED if there is a coinsurance amount indicated on the Medicare Explanation of Benefits. Enter the total coinsurance amount from the Medicare Explanation of Benefits.
37	Copay	<i>SITUATIONAL</i>	REQUIRED if there is a copay amount indicated on the Medicare Explanation of Benefits. Enter the total copay amount from the Medicare Explanation of Benefits.
38	Medicare Paid	<i>SITUATIONAL</i>	REQUIRED if there is a Medicare payment indicated on the Medicare Explanation of Benefits. Enter the total amount paid by Medicare from the Medicare Explanation of Benefits.
Part B (Bundling)			
39	Deductible	LEAVE BLANK	This field must be left blank .
40	Coinsurance	LEAVE BLANK	This field must be left blank .
Signature of Physician or Supplier			
41	Signature	REQUIRED	The provider or an authorized representative must sign the claim.
42	Date	REQUIRED	The provider or an authorized representative must indicate the original filing date.



Prior authorization is not a guarantee of payment. Approval of a request does not indicate that the member continues to be eligible for Medicaid. You are responsible for verifying Medicaid eligibility for the dates of service.

You can verify eligibility by checking the Eligibility Verification System (ELVS) hotline, which is available 24 hours a day, 7 days a week at phone (800) 338-7752, locally in Des Moines at (515) 323-9639, or by accessing the IME Provider Web Portal Services at:

<https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do>

2. Instructions for Completing Request for Prior Authorization

- ◆ **Patient Name.** Complete the last name, first name, and middle initial of the member. Use the *Medical Assistance Eligibility Card* for verification.
- ◆ **Patient Medicaid Identification No.** Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven digits and one letter).
- ◆ **Date of Birth.** Copy the member's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).
- ◆ **Provider Taxonomy No.** Enter the taxonomy number used in your Medicaid agreement.
- ◆ **Provider Phone No.** This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.
- ◆ **Provider Fax.** This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.
- ◆ **Provider NPI.** Enter the ten-digit National Provider Identifier (NPI) of the dispensing provider.
- ◆ **Dates Covered by Request.** Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period.
- ◆ **Dispensing Provider Name.** Enter the name of the provider that will provide and submit claims for the services.
- ◆ **Service Location Street Address.** Enter the street address of the dispensing provider requesting prior authorization.