Long Term Care
UB-04 Paper Claim Submission

Provider Training
Agenda

• Completing a UB-04 Paper Claim Form for Long Term Care
• Claim Submission
• Claim Samples
• Third Party Liability (TPL)
• Medicare Crossovers
• Remittance Advice (RA)
• Adjustments and Voids
• Additional Resources
Florida Medicaid Online Resources

- Florida Medicaid Provider General Handbook
- Coverage and Limitations Handbooks
- Florida Medicaid Provider Reimbursement UB-04 Handbook

Agency for Health Care Administration (Agency):
http://ahca.myflorida.com/medicaid
Completing a UB-04 Paper Claim Form for Long Term Care
### UB-04 Paper Claim Form (top section)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 PATIENT NAME</td>
<td>Patient's name</td>
</tr>
<tr>
<td>02 PATIENT ADDRESS</td>
<td>Patient's address</td>
</tr>
<tr>
<td>10 BIRTH DATE</td>
<td>Patient's birth date</td>
</tr>
<tr>
<td>12 DATE</td>
<td>Service date</td>
</tr>
<tr>
<td>16 OCCUR CODE</td>
<td>Occurrence code</td>
</tr>
<tr>
<td>17 OCCUR DATE</td>
<td>Occurrence date</td>
</tr>
<tr>
<td>25 VALUE CODE</td>
<td>Value code</td>
</tr>
<tr>
<td>26 VALUE AMOUNT</td>
<td>Value amount</td>
</tr>
</tbody>
</table>

Note: The form contains numerous fields for detailed billing information, including dates, codes, amounts, and more, which are not fully transcribed here due to the absence of specific values.
UB-04 Paper Claim Form (bottom section)
Paper Claim Submission Checklist

In order for a claim to be paid, it must be a clean claim.

Checklist for a clean claim:

- Has the claim been accurately and fully completed according to Medicaid billing guidelines?
- Is the claim accompanied by all necessary documentation and on a version 01 -12 claim form?
- Can the claim be processed and adjudicated by DXC without obtaining additional information from the provider?
UB-04 Completion Rules

Rules for completing a UB-04

- Enter all information using black or blue ink. Do not use highlighters.
- Be sure the information on the form is legible and aligned with the corresponding space.
- Only complete the fields that are required and applicable.
- If needed, use correction type. Do not use whiteout fluid.
- Complete the form by referencing the service-specific coverage and limitations handbook and the UB-04 Reimbursement Handbook, as necessary.
Enter NPI on the UB-04

As of January 1, 2011, National Provider Identifier (NPI) entries in the billing and rendering provider sections of CMS-1500 paper claims are required.

If a taxonomy code is used to create a unique map from a provider’s NPI to a Florida Medicaid ID number, the applicable taxonomy code and qualifier must be entered on paper claims.

Referring Providers must be identified using the appropriate qualifier (DN) and the NPI and taxonomy or Florida Medicaid ID, accompanied by the appropriate qualifier code (ZZ if reporting an NPI taxonomy or 1D if reporting a Florida Medicaid provider ID). The NPI entered must be valid and known to Florida Medicaid.
# Locators 1 & 3a
## UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 1        | Line 1: Provider Name  
          | Line 2: Street Address or Post Office Box  
          | Line 3: City, State, and Zip Code (plus 4)  
          | Line 4: Telephone; Fax; Country Code (if other than USA) |
| 3a       | Enter patient's unique (alphanumeric) number assigned by the provider. Any letter or number combination up to 20 digits is acceptable.  
          | This number will be included on the payment check or remittance. |
Locator 4
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Enter the appropriate four-digit code for the type of bill. See Chapter 1 of the UB-04 Reimbursement Handbook for a complete listing of Type of Bill codes.</td>
</tr>
</tbody>
</table>
Locators 5 & 6
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Enter the federal tax identification number in the format NN-NNNNNNNN.</td>
</tr>
<tr>
<td>6</td>
<td><strong>Long Term Care Facilities</strong>: Enter the start and end service dates for the month being billed in MMDDYY format. (Ex. August 21, 1997, enter as 082197.)</td>
</tr>
</tbody>
</table>
Locators 8 & 9
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8a</td>
<td>Enter patient’s Medicaid identification number only if number is different from the insured’s ID on Form Locator 60.</td>
</tr>
<tr>
<td>8b</td>
<td>Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medicaid identification card or other Medicaid proof of eligibility.</td>
</tr>
<tr>
<td>9a</td>
<td>Street Address or Post Office Box</td>
</tr>
<tr>
<td>9b</td>
<td>City</td>
</tr>
<tr>
<td>9c</td>
<td>State</td>
</tr>
<tr>
<td>9d</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>
### Locators 10 & 11

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Enter the patient’s date of birth in MMDDYYYY format. (Ex. August 21, 1997, enter as 08211997.)</td>
</tr>
<tr>
<td>11</td>
<td>Enter the letter <strong>M</strong> if the patient is male, <strong>F</strong> if the patient is female, or <strong>U</strong> if unknown.</td>
</tr>
</tbody>
</table>
### Locator 12
**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td><strong>Long Term Care Facilities:</strong> Enter the patient’s date of admission to the facility or to a new Level of Care in MMDDYYYY format. (Ex. August 21, 1997, enter as 082197.)</td>
</tr>
</tbody>
</table>
**Locator 17**
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td><strong>Long Term Care Facilities:</strong> Enter one of the below codes indicating patient status as of the discharge date.</td>
</tr>
</tbody>
</table>

**Examples of Long Term Care Discharge Status Codes:**
- 01: Home
- 03: Discharge or transfer to Skilled Nursing Facility
- 09: Hospital
- 20: Death
- 30: Still a patient
Locators 18-28
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-28</td>
<td>Long Term Care Facilities: Identify any condition relating to this bill in an alphanumeric sequence.</td>
</tr>
<tr>
<td></td>
<td>For a complete list of condition codes, see Chapter 1 of the UB-04 Reimbursement Handbook.</td>
</tr>
</tbody>
</table>
**Locator 29
UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred. (Ex. FL, GA, etc.)</td>
</tr>
</tbody>
</table>
**Locators 39-41**

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 39-41    | **Long Term Care Facilities**: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the month, even when billing a partial month.  
Always enter value code 80 for covered days and the number of days covered by the primary payer as qualified by the payer. |
### Locator 42

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 42      | **Long Term Care Facilities:** Enter the appropriate four-digit revenue code:  
• 0101 – Long Term Care days  
• 0185 – Hospital Leave days  
• 0182 – Home Leave days |
Locator 43
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td><strong>Long Term Care Facilities</strong>: Enter a written description of the related revenue categories included on this bill. Note: On multiple page claims, all required fields must be completed on each page of the claim. Enter the page number and the total number of pages on the bottom of each claim page in the Page ___ of ___ area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>42 REV CD</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RARE / HRPS CODE</th>
<th>46 SERV DATE</th>
<th>48 SERV UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<td>2</td>
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</tbody>
</table>

PAGE ____ OF ____  CREATION DATE  TOTALS
### Locator 46
#### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>42 REV CD</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RATE / HIPPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>Long Term Care Facilities: Enter the number of days associated with each revenue code. Medicaid reimburses for the date of admission, but not for the date of discharge. Include the date of admission, but do not include the date of discharge in the total number of days. If the recipient is admitted and discharged on the same day, count it as one day.</td>
</tr>
</tbody>
</table>
**Locator 47**
**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td><strong>Long Term Care Facilities:</strong> Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Long Term Care facilities should not deduct the patient responsibility.</td>
</tr>
<tr>
<td></td>
<td><strong>Line 23:</strong> Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001.</td>
</tr>
<tr>
<td></td>
<td>For Medicare crossover claims (level of care X), compute the total charge using the Medicare rate instead of the Medicaid per diem. If the Medicare rate for a recipient changed during the month, use the weighted average Medicare rate (weighted based on the number of days each rate is paid).</td>
</tr>
</tbody>
</table>
## Locators 50-51
### UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>50 A-C</strong></td>
<td><strong>Long Term Care Facilities:</strong> Enter <strong>Florida Medicaid</strong> for the Medicaid payer identification. Enter the name of the third party payer, if applicable:</td>
</tr>
<tr>
<td><strong>51 A-C</strong></td>
<td><strong>Long Term Care Facilities:</strong> For Medicaid, leave blank. If the health plan in Form Locator 50 has a number, report the number in 51 A, B, or C depending if the insurance is primary, secondary, or tertiary. If the number is unknown, leave blank.</td>
</tr>
</tbody>
</table>
## Locators 52 & 54
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 52 A-C   | **Long Term Care Facilities:** Indicate whether the patient or patient’s legal representative has signed a statement permitting the provider to release data to other organizations.  
**Code Structure:**  
- I: Informed consent to release medical information for conditions or diagnoses regulated by Federal statutes  
- Y: Provider has a signed statement permitting release of medical billing data related to a claim. |
| 54 A-C   | **Long Term Care Facilities:** Enter the amount that the provider has received toward payment of this bill prior to the billing date on this claim. Do **NOT** put the Medicaid amount due in this form locator. |
**Locators 56 & 57**

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 56       | Enter the unique NPI number assigned to the provider submitting the bill.  
*Note: If the taxonomy code is used to create a unique map from a provider’s NPI to a Florida Medicaid ID number, it is entered in Locator 81 with qualifier B3.* |
| 57 A-C   | Use for an identification number other than NPI. The provider may enter its nine-digit Medicaid provider number in Form Locator 57. |
# Locators 58 & 59

## UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>58 A-C</td>
<td><strong>Long Term Care Facilities:</strong> Enter the insured’s last name, first name, and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility.</td>
</tr>
</tbody>
</table>
| 59 A-C   | **Long Term Care Facilities:** Enter the code indicating the relationship of the patient to the identified insured.  
- **Line A:** Primary Payer, Required  
- **Line B:** Secondary Payer, Situational  
- **Line C:** Tertiary Payer, Situational  
  **Code Examples:**  
  - 01: Spouse  
  - 18: Self  
  - 19: Child  
  - 21: Unknown |
### Locator 60

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 60 A-C  | **Long Term Care Facilities:** Enter all of the insured’s unique identification numbers assigned by any payer organizations. The recipient’s ten-digit Medicaid ID number must be verified and entered. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C.  
If Medicaid is primary, enter the recipient’s Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient’s Medicaid ID number in Form Locator 60B. |
**Locator 61**
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td><strong>Outpatient Therapies and Diagnostic Imaging Services:</strong> For claims with outpatient therapy and diagnostic imaging revenue codes that require both a MediPass authorization and a prior authorization code, enter the ten digit prior authorization code (alpha numeric) in Form Locator 61.</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient and All Other Services:</strong> This field MUST be left blank.</td>
</tr>
</tbody>
</table>
### Locator 65
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 A-C</td>
<td>Enter the name of the employer who provides or might provide health care coverage for the patient.</td>
</tr>
</tbody>
</table>
**Locators 66 & 67**

**UB-04 Paper Claim Form**

<table>
<thead>
<tr>
<th>Locators</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 66       | **Diagnosis & Procedure Code Qualifier (DX):** Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported. *9:* Ninth Revision or *0:* Tenth Revision.  
By federal mandate, **ICD-10 MUST be used for all claims with dates of service on or after 10/01/2015.**  
Any claim submitted with an ICD-9 code with a date of service on or after 10/01/2015 will receive an error message and will be denied. Claims must be submitted with **EITHER** ICD-9 or ICD-10 codes. Claims submitted with both ICD-9 and ICD-10 codes will be denied. |
| 67       | **Long Term Care Facilities:** Enter the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for long term care.  
For additional information concerning this form locator, please consult the UB-04 Medicaid Provider Reimbursement Handbook. |
### Locators 76 & 77
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>Billers filling out the UB-04 form that includes an attending provider continue to use form locator 76 and its subfields. Billers do not have to enter a qualifier for an attending provider; however, billers must enter the appropriate NPI taxonomy. The attending provider’s NPI must be valid and known to Florida Medicaid. <strong>Note:</strong> A Medical license number is no longer acceptable in this form locator.</td>
</tr>
<tr>
<td>77</td>
<td>Operating Physician Name and Identifiers (OPERATING) Required when a surgical procedure code is listed on the claim. Entry of the NPI is optional for this field, but the Qualifier 0B (for state license number) and the state license number must be entered. <strong>Enter the license information in the following manner:</strong> ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending physician number.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>76 ATTENDING</th>
<th>NPI 1234567890</th>
<th>QUAL ZZ 207X00000</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST PROVIDER</td>
<td>FIRST IMA</td>
<td></td>
</tr>
</tbody>
</table>
## Locator 79
UB-04 Paper Claim Form

Billers filling out the UB-04 form that includes a referring provider can now do so by filling out form locator 79 and its subfields. Billers must enter qualifier **DN**, followed by the taxonomy or Florida Medicaid provider ID, accompanied by the appropriate qualifier code (ZZ if reporting an NPI taxonomy or 1D if reporting the Florida Medicaid provider ID). The referring provider’s NPI must be valid and known to Florida Medicaid.

### Table: Locator Instructions

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>79</td>
<td>Billers filling out the UB-04 form that includes a referring provider can now do so by filling out form locator 79 and its subfields. Billers must enter qualifier <strong>DN</strong>, followed by the taxonomy or Florida Medicaid provider ID, accompanied by the appropriate qualifier code (ZZ if reporting an NPI taxonomy or 1D if reporting the Florida Medicaid provider ID). The referring provider’s NPI must be valid and known to Florida Medicaid.</td>
</tr>
</tbody>
</table>
### Locator 80
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 80      | **Line 1:** Financial Classification (FC) Code. Enter FC followed by the three-digit Financial Classification Code in line 1 of Form Locator 80. This code identifies the relationship of the payers indicated in Form Locators 50 A-C.  
A complete list of FC codes can be found in Chapter 1 of the UB-04 Reimbursement Handbook.  
To adjust or void a previously paid claim, enter the Internal Control Number (ICN) of that claim in line 2 and the FC code in line 1. Be sure the correct type of bill code is entered in Form Locator 4.  
**Line 2:** Enter the ICN to adjust or void.  
**Line 3:** Enter Crossover on Medicare crossover claims without Third-Party Liability (TPL) payment. |
Locators 81 a-d
UB-04 Paper Claim Form

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 a-c</td>
<td>If a taxonomy code is used to create a unique map from the provider’s NPI to a Florida Medicaid ID number, enter the NPI, qualifier code B3 and the taxonomy code in Form Locator 56. Enter the taxonomy qualifier code B3 in the small field in the left-hand column and enter the taxonomy value in the middle column.</td>
</tr>
<tr>
<td>81 d</td>
<td>Long Term Care Facilities: In the first field, enter Qualifier Code “02.” In the second field, enter the established Level of Care (LOC) code to indicate the type of care that the recipient has been determined to require: 1: Skilled 2: Intermediate I 3: Intermediate II 4: State Mental Health Hospital 6-9: ICF-DD Levels of care H: Aids Per Diem U: Skilled Fragile Children under 21 X: Medicare Part A Coinsurance Payment In the third field, enter the facilities per diem. For Level of Care X, enter the total Medicare Part A payment amount divided by the number of days paid by Medicare plus the daily coinsurance amount.</td>
</tr>
</tbody>
</table>
Overview of NPI Completion Fields
Claim Certification

Because the UB-04 Paper Claim Form does not have the provider's signature, the provider’s endorsed signature on the back of the remittance check issued by the Medicaid fiscal agent takes the place of a signature on a paper claim form.

The provider’s signature on the check acknowledges the submission of the claim and the receipt of the payment for the claim. It also certifies that the claim is in compliance with the conditions stated on the back of the paper claim form and with all federal and state laws.

Any provider who utilizes the electronic funds transfer system is certifying with each use of the system that the claim(s) for which the provider is being paid is in compliance with the provisions found on the back of the paper claim form and with all federal and state laws.
Overview of the Web Portal and Remittance Advice
Claim Submission

A **clean claim** for services rendered must be received by Florida Medicaid or its fiscal agent no later than 12 months from the Date of Service (DOS).

- **Third Party Liability Claims (TPL)**
  Providers also have 6 months from the TPL Explanation of Benefits (EOB) date.

- **Medicare Crossover Claims**
  The filing limit for crossover claims is the greater of either 36 months from the date of service or 12 months from Medicare’s adjudication date.

- **Adjustments**
  Providers have 12 months from the payment date to make an adjustment. Claims may be submitted directly to DXC Technology.

- **Voids**
  Claims can be submitted directly to DXC Technology with no time limit. Replacements for voids must be submitted to the area office within 6 months of the date of the void if over 12 months from the DOS.
Where to send LTC UB-04 Claims

Send LTC UB-04 Claims to:
DXC Technology
Nursing Home Claims
P.O. Box 7082
Tallahassee, FL 32314-7082

Note: Paper claim submissions applicable to Out-of-State providers only.
Claim Samples
Long Term Care Facility UB-04 Paper Claim Form (top section)
Long Term Care Facility UB-04 Paper Claim Form (bottom section)
Long Term Care Level of Care X (top section)
Long Term Care Level of Care X Form (bottom section)
Third Party Liability
Third Party Liability

Third Party Liability (TPL) is the obligation of any entity, other than Medicaid, to pay all or part of the cost of the recipient’s medical care.

- Providers must verify recipient eligibility prior to rendering services.
- Medicaid is the payer of last resort.
- If a recipient has other insurance coverage, the provider must bill the primary insurance prior to billing Medicaid.
Medicaid Reimbursement for TPL Claims

- If the amount of the Third Part Liability (TPL) payment meets or exceeds the Medicaid fee for the service, Medicaid will not reimburse for the service.

- If the amount is less than the Medicaid fee, Medicaid will reimburse the difference between the Medicaid fee and the third party payment, minus any Medicaid copayment or coinsurance.

- All TPL paper claims must be submitted with the corresponding TPL Explanation of Benefits (EOB).
# Long Term Care TPL UB-04 Paper Claim Form (top section)

![Image of UB-04 Paper Claim Form]

**Florida Nursing Home**
123 Palm Street
Anywhere Florida 33333-1234
(850) 999-8888

**Resident, Florida A**
108 Main St.
Anywhere FL 33333

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0101</td>
<td>Long Term Care days</td>
<td>8100.00</td>
</tr>
</tbody>
</table>

**Diagnosis Codes**
- 31
- 200.00

**Other Codes**
- 0291918
- 061516
Long Term Care TPL UB-04 Paper Claim Form (bottom section)

![UB-04 Paper Claim Form Image]

**Florida Medicaid**
- Resident: Florida A
- Resident: Florida A

**TPL Insurance**
- Resident: Florida A
- Resident: Florida A

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FC 210</td>
<td></td>
<td>140.00</td>
</tr>
</tbody>
</table>
Remittance Advice
Remittance Advice (RA) Options

Electronic Remittance Advice (ERA) Images

Providers can view an image of their RAs via the secure Web Portal under Reports.

X12 835

Providers download electronic files via the secure Web Portal under Trade Files.
## Sample Remittance Advice

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Date of Service</th>
<th>Amount Billed</th>
<th>Allowance</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01234567</td>
<td>01/01/2023</td>
<td>$100.00</td>
<td>$80.00</td>
<td>$80.00</td>
</tr>
<tr>
<td>89012345</td>
<td>02/15/2023</td>
<td>$120.00</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>78945612</td>
<td>03/31/2023</td>
<td>$150.00</td>
<td>$120.00</td>
<td>$120.00</td>
</tr>
</tbody>
</table>

**Total Long Term Care Claims Paid:** $475.00
Internal Control Number (ICN)

An **Internal Control Number (ICN)** is a 13 digit number that appears on the Remittance advice (RA) and is unique to each claim, regardless of status.

**Sample Region Codes:**
- 22 – Web Portal claim with no attachments
- 23 – Web Portal claim with attachments
- 10 – Paper claim with no attachments
- 11 – Paper claim with attachments
- 59 – Web Portal adjustment or void

<table>
<thead>
<tr>
<th>Region</th>
<th>Julian Date</th>
<th>Batch</th>
<th>Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Year and day of the year</td>
<td>999</td>
<td>Internal use only</td>
</tr>
<tr>
<td></td>
<td>Ex: 01/09/19</td>
<td>Internal use only</td>
<td></td>
</tr>
</tbody>
</table>
The **Reports Section** allows the user to search for a specific Florida Medicaid-issued report by Report name and Date.

The default Download Format is PDF.

Reports can be pulled for up to three months.
Adjustments and Voids
Adjustment Information

- You can only adjust a paid claim.
- A provider has 12 months from the payment date to adjust.
- The adjustment claim must match the original claim with the exception of the corrections.
- The adjustment will replace the original claim.
- If you have a claim where a line item was paid and a line item was denied, simply resubmit the denied line.
- Send claim directly to DXC Technology.
## Long Term Care TPL UB-04 Claim Adjustment Form (top section)

![UB-04 Claim Form Image]

### Claim Details

- **Provider Name**: Florida Nursing Home
- **Address**: 123 Palm Street, Anywhere, Florida 33333-1234
- **Provider Phone**: (850) 999-8888
- **Claim Number**: SB-1234567
- **Date of Service**: 04/29/1918
- **Provider ID**: F 061516
- **Resident Name**: Resident, Florida A
- **Address**: 108 Main St, Anywhere, FL 33333
- **Date of Birth**: 04/29/1918
- **Sex**: F
- **Race**: 0
- **Admission Date**: 01/01/1918
- **Discharge Date**: 04/29/1918
- **Death Date**: 0
- **Diagnosis Code**: 000.00
- **Procedure Code**: 31 8100.00
- **Days of Stay**: 30
- **Claims Period Start**: 02/01/19
- **Claims Period End**: 04/29/19
- **System Error Code**: 0
- **Adjustment Code**: 0
- **Adjustment Reason**: Long Term Care days

### Adjusted Charges

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Long Term Care days</td>
<td>8100.00</td>
</tr>
</tbody>
</table>
# Long Term Care UB-04 Claim Adjustment Form (bottom section)

![Form Image]

<table>
<thead>
<tr>
<th>Service Unit</th>
<th>Description</th>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>125.10</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>125.10</td>
<td></td>
<td>100.00</td>
</tr>
</tbody>
</table>

---

**Provider Information**

- **Provider Name**: Florida Medicaid
- **Provider ID**: 012345678
- **Insured's Name**: Resident, Florida A
  - **Insured ID**: 1234567890

---

**Patient Information**

- **Name**: Smith, Jane
- **EXPLANATION**: Filing of a corrected UB-04 due to an error in the original submission.

---

**UB-04 Instructions**

- Review all details and ensure accuracy before submission.
- Attach all necessary supporting documentation for adjustments.

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**Notes**

- Date of Service: February 21, 2019
- Submission Date: [Insert Date Here]

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**Acknowledgement**

- **Acknowledged**: [Insert Acknowledged By Here]
- **Date**: [Insert Date Here]
Void Information

- You can only void a paid claim.
- There is no time limit to submit a void claim.
- A provider has 6 months from the date of the void to request an exception from the area office if the claim is over 12 months from the Date of Service (DOS).
- A void will result in a complete recoupment of the original payment made under the ICN that is being voided.
Long Term Care TPL UB-04 Claim Void Form (top section)
Long Term Care TPL UB-04 Claim Void Form (bottom section)
Where to send Adjustments and Voids

Send Adjustments and Voids to:
DXC Technology
Adjustments and Voids
P.O. Box 7082
Tallahassee, FL 32314-7082

Note: Paper claim submissions applicable to Out-of-State providers only.
First, find the claim that needs to be adjusted or voided by performing a Claim Search. Click **Claims, Claim Search**, and open the claims that needs to be adjusted or voided.

To adjust a claim, open the claim, make any necessary changes, then click the **adjust** button.

To void a claim, click the void button at the bottom of the page.

Providers have 12 months from the Paid Date to adjust a claim.
Additional Resources
For more detailed information on how to fill out an LTC UB-04 paper claim, you can access the applicable service-specific Coverage and Limitations Handbook on the AHCA site, at http://ahca.myflorida.com/medicaid/review/Promulgated.shtml, choose Service-Specific Policies, and then click on the PDF, in the Reference Material Column, to the left of the Rule name that applies to the Handbook for which you are searching.
Web Based Training (WBT)

Web-Based Training (WBT) courses are offered on a variety of subjects and are free to all Florida Medicaid providers.

WBTs can be accessed 24 hours a day, seven days a week.

To access available WBTs, please visit the Medicaid Web Portal.
Summary

- Completing a UB-04 Paper Claim Form
- Claim Submission
- Claim Samples
- Third Party Liability (TPL)
- Medicare Crossovers
- Remittance Advice (RA)
- Adjustments and Voids
- Additional Resources
We’re Here to Help!

Automated Voice Response System (AVRS)
1-800-239-7560

Provider Services Main Telephone Line:
For billing questions, claim status:
1-800-289-7799
- Option 4: Provider Enrollment
- Option 5: Password Reset
- Option 7: Provider Services Contact Center & PFS Representatives

Magellan Medicaid Administration, Inc.
For pharmacy questions:
1-800-603-1714

Electronic Data Interchange – EDI
For 837 and electronic transmission questions:
1-866-586-0961

Thank you for attending training.