

| Item | Name | Instructions | | | | |
|----------|---|--|----------|--|----------|------------------------|
| 1 | Medicaid | Check Medicaid as the type of health insurance. | | | | |
| 1a | Insured's I.D. Number | Enter the 12 digit Billing Number from the consumer's Medical card (Ohio Medicaid, Disability Assistance, etc.). Do not use any number other than the one designated on the medical card as "Billing Number." | | | | |
| 2 | Patient's Name | Enter the consumer's last name, first name, and middle initial, if any, as shown on the medical card. | | | | |
| 3 | Patient's Birth Date and Sex | Leave blank. | | | | |
| 4 | Insured's Name | Leave blank. Consumer and insured must always be the same. | | | | |
| 5 | Patient's Address | Leave blank other than for abortion claims. | | | | |
| 6 | Patient Relationship to Insured | Leave blank. For Medicaid and Disability Assistance, consumer and insured will always be the same | | | | |
| 7 | Insured's Address | Leave blank. | | | | |
| 8 | Patient Status | Leave blank. | | | | |
| 9 | Other Insured's Name | If the consumer is covered by a private health insurance policy (other than Medicare), enter the name of the person who holds the insurance policy. For example, Jane Doe is covered under her father's (John's) Blue Cross plan. The name of Jane's father (John Doe) would go in this space. | | | | |
| 9a | Other Policy or Group Number | Enter the policy and/or group number of the private insurance policy (other than Medicare) referred to in Item 9. | | | | |
| 9b | Date of Birth/Sex | Leave blank. | | | | |
| 9c | Employer Name | If available, enter the name of the employer or holder of an individual private insurance policy. | | | | |
| 9d | Insurance Plan or Program Name | Enter the name of the insurance plan listed in 9a. | | | | |
| 10a-c | Patient's Condition | Check "YES" or "NO" to indicate whether employment, auto, or other accident involvement applies to one or more of the services described in Item 24. Transportation Provider: Leave blank. | | | | |
| 10d | Reserved for Local Use (aka: Other Source) | Medicaid uses this space for information regarding other sources of payment for services. Only one character may be entered in this space. Enter 1-8 from the other source code below if you have received payment for the service from a source other than Medicaid or Medicare. When 1-8 is entered in this block, the amount collected must be entered in block 29. <table style="margin-left: 40px;"> <tr> <td>1</td> <td>Self/Family/spenddown or patient liability</td> </tr> <tr> <td>2</td> <td>Blue Cross/Blue Shield</td> </tr> </table> | 1 | Self/Family/spenddown or patient liability | 2 | Blue Cross/Blue Shield |
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| 3 | Private Carrier | |
| 4 | Employer or Union | |
| 5 | Public Agency | |
| 6 | Other (enter the name and address of the source in the provider remarks section) | |
| 7 | Psychiatric Reduction | |
| 8 | FQHC/Rural Health Center Managed Care Supplemental Payment (See FQHC rule: 5101:3-28-07) | |
| <p>Enter R, P, F, L, E, S, or X if you have billed all third-party insurers first and you have not received payment from a third party insurer within ninety days, but there are indications of private (non-Medicaid/non-Medicare) health insurance coverage for any eligible individual that is listed on the Medical card of the consumer. Documentation to justify use of codes R, P, F, L, S, E, and X must be retained for future audit purposes.</p> | | |
| <p>R No Response From Carrier--There was no response from the insurance carrier for 90 days. A claim with this code may not be submitted until 91 days after the date of treatment.</p> | | |
| <p>P No Coverage for this Consumer Billing Number--The provider has confirmed there is private health insurance (other than Medicaid or Medicare) for some eligible individuals listed on the consumer's Medical card, but the consumer is not covered. If the Medical card indicates the consumer has third-party insurance but you have verified that the consumer does not have third-party insurance, complete the JFS 06614 form.</p> | | |
| <p>F No coverage for All Consumer Billing Numbers--There is no private health insurance (other than Medicaid or Medicare) for any eligible individual listed on the medical card. If the medical card indicates all the eligible individuals listed on the medical card have third-party insurance and you have verified all the eligible individuals listed on the card do not have third-party insurance, complete the JFS 06614 form.</p> | | |
| <p>L Disputed or Contested Liability--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the coverage for the billed service is disputed or contested by the insurance carrier</p> | | |

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| | | <p>due to a pre-existing condition or other policy limitation. Do not use this code for when the insurance carrier is requesting additional information.</p> <p>S Non-Covered Services--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the policy does not cover the services being billed. This code should also be used when the policy does not cover the services being billed or when the amount billed has been applied to the insurance deductible.</p> <p>E Insurance Benefits Exhausted--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the policy benefits for the billed services have been exhausted.</p> <p>X Non-Cooperative Consumer--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the consumer refused to cooperate in the collection effort. Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third-party insurer.</p> <p>Leave Blank, if there is not a payment from another source and there is no indication of private health insurance coverage (non-Medicaid/non-Medicare) for the consumer.</p> |
| 11 | Insured's Policy Group | Leave blank. This is always the consumer's Billing Number and is only reported in Item 1a. |
| 11a-c | | Leave blank. |
| 11d | | Check "YES" or "NO" to indicate if there is any insurance other than Medicaid or Medicare. If yes, complete Item 9. |
| 12 | Signature | May be left blank if consumer does not have third-party insurance or any other payment source (See note below). |
| 13 | Signature | May be left blank if the consumer does not have third-party or any other payment source (See note below). |
| | | <p>Note: Signatures in items 12 and 13 are not required by Medicaid. However, if the consumer has third-party coverage in addition to Medicaid, the signatures may be necessary for reimbursement from the third-party insurer. Medicaid does not reimburse for services denied by the third-party insurer or uncollected payments due to a providers failure to secure the appropriate signatures on the claim.</p> |
| 14 | Date of Current Illness, Injury or Pregnancy | Complete this field for pregnancy only. Enter the six digit (MMDDYY) or eight digit (MMDDCCYY) date of the |

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| | | last menstrual period. |
| 15 | Same or Similar Illness | Leave blank. |
| 16 | Dates Patient Unable to Work in Current Occupation | Leave blank. |
| 17 | Name of Referring Physician | Complete only if using 9111115 in Item 17a. |
| 17a | ID Number of Referring Physician | <p>Do not enter an NPI in this field.</p> <p>Physicians, podiatrists, clinics, advanced practice nurses: If the consumer was referred to you, enter the referring physician's Medicaid provider number. This field must be completed when billing for consultative or referral services or billing for services provided to a PACT consumer for whom you are not the designated physician. If the referring provider's provider number is not available, enter 9111115 in this space and enter the referring physician's name in Item 17.</p> <p>FQHC's and RHC: Enter the Managed Care Plan's Medicaid number when billing for supplemental payments.</p> <p>Medical Supply Provider: Enter the Medicaid number of the prescribing provider.</p> <p>Laboratory Provider: Please leave blank unless the procedure code is one designated as requiring a referring provider number.</p> <p>Transportation Provider: For all non-emergency transport a physician must certify that all ambulance and ambulette nonemergency services are medically necessary. Enter the Medicaid provider number of the attending or ordering physician.</p> |
| 18 | Hospitalization Dates | <p>Leave blank.</p> <p>Home Health and Private Duty Nursing Provider: Enter the six digit (MMDDYY) date of discharge in the "To" field when billing services provided after as a result of a post-hospital stay. The date of discharge can never be greater than 60 days from the date of service recorded in item 24a.</p> |
| 19 | Reserved for Local Use (aka: Remarks) Medicaid | Leave blank unless the service you are billing for is subject to a co-payment as described in rule 5101:3-1-09 |

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| | <p>Co-Payments</p> | <p>of the Administrative Code. If a co-payment does apply, but meets one of the exclusions described in the above rule, and a co-payment should not be charged/collected, providers must bill ODJFS using one of the 10-byte exclusion codes provided in the table below to indicate that a co-payment should not be taken for the service provided to the Medicaid consumer.</p> <p>Note: If an exclusion applies and must be entered into the remarks field, no other remarks may be entered prior to the copayment exclusion code on the claim. Co-payment exclusion codes must always come first in the remarks field to ensure proper adjudication of the claim.</p> <table border="1" data-bbox="667 741 1409 1407"> <thead> <tr> <th data-bbox="667 741 1040 814">Exclusion Description</th> <th data-bbox="1040 741 1409 814">Exclusion Code (Enter into Remarks Field)</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="667 814 1409 1037"> <p>Important: The caret (^) denotes that a space must be placed between the qualifier (e.g. COPAY) and the exclusion code (e.g. PREG). This space must be entered for the claim to adjudicate correctly and must be entered regardless of the exclusion code being sent for payment.</p> </td> </tr> <tr> <td data-bbox="667 1037 1040 1184"> <p>If the consumer is pregnant or the pregnancy ended recently (up to 90 days ago)</p> </td> <td data-bbox="1040 1037 1409 1184"> <p>COPAY ^ PREG</p> </td> </tr> <tr> <td data-bbox="667 1184 1040 1257"> <p>If the consumer is receiving hospice services</p> </td> <td data-bbox="1040 1184 1409 1257"> <p>COPAY ^ HSPC</p> </td> </tr> <tr> <td data-bbox="667 1257 1040 1407"> <p>If the consumer received services subject to a copayment due to an emergency</p> </td> <td data-bbox="1040 1257 1409 1407"> <p>COPAY ^ EMER</p> </td> </tr> </tbody> </table> <p>Note: Exclusions for consumers either under the age of 21, or who are receiving family planning services or who are institutionalized (i.e. reside in a nursing facility or ICF-MR) will not need to be indicated in the remarks field for the co-payment exclusion to take effect. ODJFS' adjudication system will automatically detect these exclusions and will not take a copayment on services rendered to these consumers.</p> | Exclusion Description | Exclusion Code (Enter into Remarks Field) | <p>Important: The caret (^) denotes that a space must be placed between the qualifier (e.g. COPAY) and the exclusion code (e.g. PREG). This space must be entered for the claim to adjudicate correctly and must be entered regardless of the exclusion code being sent for payment.</p> | | <p>If the consumer is pregnant or the pregnancy ended recently (up to 90 days ago)</p> | <p>COPAY ^ PREG</p> | <p>If the consumer is receiving hospice services</p> | <p>COPAY ^ HSPC</p> | <p>If the consumer received services subject to a copayment due to an emergency</p> | <p>COPAY ^ EMER</p> |
| Exclusion Description | Exclusion Code (Enter into Remarks Field) | | | | | | | | | | | |
| <p>Important: The caret (^) denotes that a space must be placed between the qualifier (e.g. COPAY) and the exclusion code (e.g. PREG). This space must be entered for the claim to adjudicate correctly and must be entered regardless of the exclusion code being sent for payment.</p> | | | | | | | | | | | | |
| <p>If the consumer is pregnant or the pregnancy ended recently (up to 90 days ago)</p> | <p>COPAY ^ PREG</p> | | | | | | | | | | | |
| <p>If the consumer is receiving hospice services</p> | <p>COPAY ^ HSPC</p> | | | | | | | | | | | |
| <p>If the consumer received services subject to a copayment due to an emergency</p> | <p>COPAY ^ EMER</p> | | | | | | | | | | | |
| 20 | Outside Lab | Leave blank. | | | | | | | | | | |
| 21 | Diagnosis or Nature of Illness or Injury | Enter all the ICD-9 diagnosis codes in order of significance, up to a maximum of four, that apply for the services listed in item 24. | | | | | | | | | | |

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| | | <p>Note: Medicaid will read only primary and secondary codes. A diagnosis code must be present on all claims other than independent laboratory, physiological laboratory, portable x-ray, transportation, and waiver claims.</p> |
| 22 | Medicaid Resubmission Number | <p>Under "Original Ref. No." enter the 17-digit transaction control number (TCN) associated with any claim being resubmitted that is older than 1 year (365 days). If additional space is needed, use Block 19. These claims must be submitted with a JFS 06653 Medical Claim Problem form to:</p> <p style="text-align: center;">Provider Network Management Section P.O. Box 1461 Columbus, Ohio 43216-1461</p> |
| 23 | Prior Authorization Number | <p>Complete only if prior/payment authorization is required for any of the services billed. Use the ODJFS assigned six digit number from the approved "Prior Authorization" notification. Refer to the appropriate Medicaid program rules to determine what services require prior authorization.</p> <p>Transportation Provider: Complete only if Prior Authorization is required for the services billed.</p> <p>ODJFS Administered Waiver Provider: Complete for supplemental adaptive assistive device services (T2029) or home modification services (S5165) using the instructions listed above.</p> <p>Private Duty Nursing Provider: Prior authorization number is required on dates of service on or after 10/01/06 when billing the procedure code/modifier combination of T1000 and U5 or U6 unless the consumer is enrolled on a ODJFS-administered home and community based waiver.</p> |
| 24a | Date(s) of Service | <p>Enter the date the service was rendered in the "From" section. The date is entered using the six-digit (MMDDYY) format. Enter all six digits consecutively without dashes, slashes, or spaces. Do not enter a date under the "To" section.</p> <p>Note: A separate line is required for each date of service.</p> <p>Note: Failure to enter a date in "From" column will cause</p> |

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| | | <p>the line item to reject.</p> <p>Note: All services must be billed to Medicaid within 365 days of the date of service.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Each line must represent a single visit. Multiple visits of the same service must be billed on separate lines but on the same claim. A visit for the provision of the same service or service with the same scope of service must be separated by two hours, unless the private duty nursing service has the exceptions found in rules 5101:3-12-02 and 5101:3-12-04 of the Administrative Code. Note: If a visit begins in the late evening and continues after midnight, the visit must be billed as a single visit with the date of service being the date the visit began.</p> |
| 24b | Place of Service | <p>All claims, other than those submitted by independent laboratories, portable x-ray suppliers, transportation providers and independent physiological laboratories, require a place of service. Enter the appropriate place of service from the list below:</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 Birth Center 26 Military Treatment Facility 31 Skilled Nursing Facility 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 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 71 State or Local Public Health Clinic |

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| | | <p> 72 Rural Health Clinic 73 Clinic, Not Otherwise Specified 81 Independent Laboratory 99 Other Unlisted Facility </p> <p> Home Health Provider (Medicaid Certified Home Health Agency): Enter 12, since services can only be delivered in the home. </p> <p> Private Duty Nursing Provider: Enter 12, since services are usually delivered in the home unless community exceptions are met. Enter 99 if community exceptions are met. </p> <p> ODJFS Administered Waiver Provider: Enter 12 for services rendered in the home, 99 for services rendered outside the consumer’s home unless the service is out-of-home respite. For out-of-home respite enter either 31, 32, 33, or 54 as appropriate. </p> |
| 24c | Type of Service | Leave blank. |
| 24d | Procedures/Services /Supplies | <p>PROCEDURE CODES</p> <p>Enter the five character/digit Healthcare Common Procedure Coding System (HCPCS) code which corresponds to the service rendered.</p> <p>FQHC, RHC, and OHF’s: Bill the appropriate five-digit encounter code followed immediately on the next line by the HCPCS code(s) that correspond to the services rendered. HCPCS codes must follow the encounter code to which they relate.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Please note that codes specific to home health, private duty nursing, waiver (nursing/personal care) or waiver (other waiver services) cannot be billed on the same claim. For example, procedure codes G0154, T1000, T1019 or H0045 cannot be billed on the same claim.</p> <p>MODIFIERS</p> <p>In certain instances a two character/digit modifier will be required depending on the service. When entering a code with the modifier, enter the two character/digit modifier</p> |

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| | | <p>directly behind the solid hash line using no spaces, dashes or slashes.</p> <p>In other instances, multiple two character/digit modifiers will be required depending on the service. Up to four modifiers may be entered per line. When entering a code with multiple modifiers, enter the first character/digit modifier directly behind the solid hash line using no spaces, dashes or slashes. Enter any additional modifiers, up to six characters of two character/digit modifiers, behind the next hash line using no spaces, dashes or slashes.</p> <p>FQHCs: See the listing of HIPAA compliant code and modifiers for each type of encounter in MAL 442. RHCs: Bill T1015 modified by U1. See MAL 440 for more details. OHFs: See the listing of HIPAA compliant code and modifiers for each type of encounter in MAL 441.</p> <p>Transportation Provider: For example, if a consumer is a second passenger (U1) and is receiving an ambulette service in an ambulance (U3) and is being transported from a residence to a physician's office (RP) and upon arrival finds the physician is unavailable and has cancelled the appointment (U6). Using the instructions above the entered line would look like: A0428 RP U1U3U6.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: For example, if a consumer (child) is receiving increased hours of the home health nursing service (U5), for the second nursing visit that day (U2), for home infusion (U1), in a group setting (HQ), the entered line (visit) would look like: G0154 U5 U2U1HQ. Modifiers can be presented in any order. Note: The Medicaid maximum will be 75% of the unmodified total Medicaid maximum when the "HQ," group setting modifier is billed. The entire line (visit) is modified with the HQ group setting even if only a portion of the visit met the definition of group setting/visit. Modifiers for multiple visits U2 and U3 are only used on when the same service/procedure code is used.</p> |
| 24e | Diagnosis Code Indicator | Leave blank. |
| 24f | Charges | Enter your usual and customary fee for the service listed |

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| | | <p>on this line. See "Billing Note" below.</p> <p>Note: Provider types (04) OHF, (05) RHC, and (12) FQHC do not enter charges for line items subsequent to the encounter code. No deductible, coinsurance, or co-payment amounts are to be collected from Medicaid consumers whether Medicaid is the consumer's primary insurance or secondary insurance. Deductibles and co-payments should be reported as instructed below.</p> <p>Note: The department recognizes three private insurance arrangements:</p> <p>Arrangement 1: A fee-for-service plan where the provider has no agreement with the payer to accept a certain fee. For Arrangement 1, the provider would enter the usual and customary charge in item 24f and the amount paid by the private insurer in item 29. For example, if Dr. Smith charges \$30 for a visit and the insurance company pays \$20, Dr. Smith would enter \$30 in item 24f and \$20 in item 29.</p> <p>Arrangement 2: A fee-for-service plan where the provider has entered into an agreement to accept a rate (usually a fee below the provider's usual and customary rate). For Arrangement 2, the provider would enter the agreed fee amount in item 24f and the amount paid by the insurer in item 29. For example, Dr. Smith's usual and customary rate for code 99201 is \$20 but she has an agreement with Blue Cross to accept \$15. Blue Cross pays Dr. Smith \$10 of the \$15 and the remaining \$5 is the co-payment. In this case, Dr. Smith must enter \$15 in item 24f for any Medicaid consumer covered under this Blue Cross policy and \$10 in item 29.</p> <p>Arrangement 3: A managed care plan (e.g., HMO, PPO, IPA) where the plan pays the provider on a fee-for-service basis. For Arrangement 3, the provider would enter the fee-for-service payment made by the managed care plan plus the co-payment amount required by the managed care plan in item 24f, and the fee-for-service amount paid by the managed care plan in item 29. For example, Dr. Smith is paid \$15 by the managed care plan for every visit and there is a \$10 co-payment. In this case Dr. Smith would enter \$25 (fee-for-service payment plus the co-payment) in item 24f and \$15 in item 29.</p> |

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| 24g | Units | <p>Enter the number of units of service provided if more than one. Only whole numbers may be reported. The following services may be reported in multiple units on one line: Allergy tests, Add-on codes specified in Appendix D of the CPT book, time-based codes, Medical Supplier Services, J codes, or Q Codes for injectables, and certain diagnostic and therapeutic services.</p> <p>Anesthesia Provider: Enter the number of actual anesthesia minutes in the unit field.</p> <p>Transportation Provider: For loaded mileage codes, enter the total number of loaded miles. For all other codes, enter a "1" (i.e., base rate codes).</p> <p>FQHCs, OHFs, and RHCs: Leave blank unless the service is anesthesia. For anesthesia, enter the number of minutes.</p> <p>Note: OHFs: Laboratory and radiology services must be billed as an encounter. Do not bill units of service for these services.</p> <p>Hospice Provider: For procedure codes T2042, T2044, T2045 and T2046, enter only a "1". For procedure code T2043, enter the number of hours in the visit.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Enter the appropriate number of units for the service/visit rendered. The visit is billed using a time/unit structure and base/unit rate combination based on the total length of the visit, and is reimbursed up to the Medicaid maximum.</p> |
| 24h | EPSDT/Family Planning | <p>HEALTHCHEK/EPSDT</p> <p>Enter an "E" in this block if the service is a Healthchek and no follow-up services were required.</p> <p>Enter an "R" in this block if the service was Healthchek and follow-up is required and a referral is made.</p> <p>FAMILY PLANNING</p> <p>Enter an "F" in this blank if the service is related to family planning.</p> |

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| | | <p>Transportation Provider: Leave blank.</p> <p>Hospice Provider: Leave blank.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Leave blank.</p> |
| 24i | EMG | Leave blank. |
| 24j | COB | Leave blank. |
| 24k | Reserved for Local Use (aka: Prescription Number) | <p>Leave blank for claim types other than medical supplier services.</p> <p>Medical Supplier Service Provider: Enter the prescription number or invoice number of the item dispensed. This field can contain a maximum of six characters.</p> |
| 25 | Federal Tax I.D. Number | Leave blank. |
| 26 | Patient's Account No. | (Optional) This is for the provider's use in identifying consumers and allows use of up to nine numbers or letters (no other characters are allowed.) If used, this number will appear on the remittance advice under "Med Rec." |
| 27 | Accept Assignment | <p>Leave blank.</p> <p>Note: Providers must always accept assignment for Medicaid consumers.</p> |
| 28 | Total Charge | Enter the total charge for all services on this invoice. This number should be the sum of charges in column F. |
| 29 | Amount Paid (aka Other Source) | <p>Enter the amount collected from all sources other than Medicare. If the amount collected from all sources other than Medicare exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment. (When an amount is entered in this item, item 10d must also be completed.) For claims involving Medicare coverage, see Medicaid/Medicare Crossover JFS 06780 billing instructions.</p> <p>Hospice Provider: Enter the amount of spenddown or patient liability, even if it has not been collected. If the total patient liability (PL) exceeds the total in item 28 on the paper invoice, then enter the remaining amount to the next paper invoice form and continue this process until patient liability is exhausted. Account for each day service was rendered.</p> <p>Hospice patient in the community: Enter the total</p> |

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| | | amount of spend-down as determined by the county department of job and family services. Hospice patient in LTCF: Enter total or remaining spenddown or PL as identified by the LTCF. |
| 30 | Balance Due (aka Net Charge) | Enter the difference between the total charge (Item 28) and the amount received from other sources (Item 29). |
| 31 | Signature | The provider or his representative should sign and date the claim form here. |
| 32 | Name and Address of Facility Where Services Were Rendered | Leave blank. |
| 33 | Provider Number, Name and Address | <p>Enter the provider's name, mailing address, city, state, and zip code. Enter the seven digit Medicaid provider number as follows:</p> <p>Do not enter an NPI in either the PIN# or Group#.</p> <p>PIN#: Enter the Medicaid provider number assigned to the provider billing for the service in the space directly to the right of "PIN#." When the billing provider is a group practice (e.g., physician group, podiatry group, chiropractic group, APN group etc.), the provider number assigned to the individual who performed the service must go in this space and the provider number assigned to the group practice must be entered in the space directly to the right of "GRP#."</p> <p>FQHC, RHC, and OHF's: Enter the provider number of the facility not the individual provider number.</p> <p>Hospice Provider: When a hospice agency is billing for the provision of physician services, enter the rendering provider's Medicaid provider number.</p> <p>GRP#: The space directly to the right of "GRP#" must be left blank, unless billing for a group practice. A provider number assigned to an individual practitioner, clinic, DME dealer, Ambulatory Surgery Center, etc., should never be entered in this space (See "PIN#" instructions).</p> <p>If billing for a group practice, enter the Medicaid provider number assigned to the group in the space directly to the right of "GRP#." Only provider numbers assigned as provider types 07, 21, 23, 31, 57, 61, 62, 63, 64, 66, 67 and 68 should appear in this space. When the billing</p> |

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| | | <p>provider is in a group practice, the space directly to the right of "PIN#" must also be completed with the individual number of the servicing provider.</p> <p>Hospice Provider: When a hospice agency is billing for the provision of physician services, enter the hospice agency's Medicaid provider number.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Leave blank.</p> |
| <p>MAIL CMS 1500 CLAIMS TO: The Ohio Department of Job and Family Services P.O. Box 7965 Akron, Ohio 44306 DO NOT FOLD CLAIM FORM</p> | | |