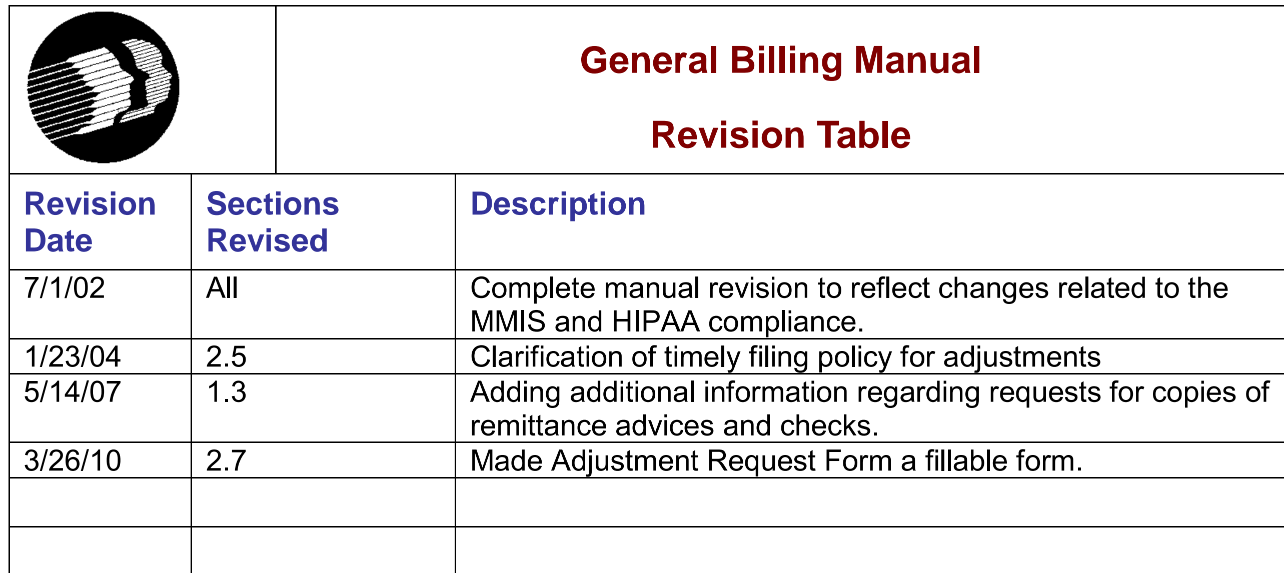

# General Billing Manual

## Revision Table

| Revision Date | Sections Revised | Description |
|---|---|---|
| 7/1/02 | All | Complete manual revision to reflect changes related to the MMIS and HIPAA compliance. |
| 1/23/04 | 2.5 | Clarification of timely filing policy for adjustments |
| 5/14/07 | 1.3 | Adding additional information regarding requests for copies of remittance advices and checks. |
| 3/26/10 | 2.7 | Made Adjustment Request Form a fillable form. |
| | | |
| | | |

This page intentionally left blank

# General Billing Information

## Table of Contents

Main Menu


**1.0 Claims Processing**

1.1 Receiving and Screening Claims
1.2 Processing of Claims
1.3 Payment Cycle
1.4 Remittance Advice
1.5 Banner Page
1.6 RA Banner Page Example
1.7 Claim Status
1.8 Paid Claims
1.9 Professional Paid Claims RA Example
1.10 Pended Claims
1.11 Pending Claims RA Example
1.12 Adjusted Claims
1.13 Professional Adjusted Claims RA Example
1.14 Remaining Balance on Previous Adjustments
1.15 Remaining Balance on Previous Adjustments RA Example
1.16 Earnings Data
1.17 Earnings Data RA Example
1.18 Resubmitting Claims

**2.0 Adjustments**

2.1 Adjusting a Paid Claim
2.2 Remittance Advice
2.3 Adjustment of Inaccurate Medicare/Medicaid Payments
2.4 Overpayment/Refund Adjustments
2.5 Adjustment Filing Limitation
2.6 Completion of the Adjustment Request Form

2.7 Adjustment Request Form

2.8 Change of Provider Information Authorization Form

2.9 Affiliation Roster

## 3.0 Written Inquiry

3.1 General Information

3.2 Completion of the Provider Inquiry Form

3.3 Provider Inquiry Form

## 4.0 Telephone Inquiry

4.1 Provider Telephone Inquiry

## 5.0 Ordering Forms

5.1 Completion of the Order Form

5.2 DMAP Order Form

## 6.0 Electronic Claims Submission

6.1 General Information

6.2 Methods of Submission

6.3 How to Submit Claims Electronically

6.4 Contact Address and Telephone Number

# 1.0 Claims Processing

This section is dedicated to discussing how claims are processed by HP Enterprise Services, LLC, the fiscal agent for the Delaware Medical Assistance Program. This section covers the following areas related to claims processing.

- Receiving and Screening Claims - Discusses what occurs when the claim arrives at HP Enterprise Services, LLC' office and how the claim is screened.
- Processing of Claims - Discusses how each claim is processed and as a result of processing, details the categories that claims fall into: paid, denied, in process.
- Payment Cycle - After each payment cycle providers who had claims processed in that cycle will receive at least one of the following in the mail or electronically: Remittance Advice, Electronic Funds Transfer or a check.

## 1.1 Receiving and Screening Claims

When your claim is received by HP Enterprise Services, LLC's claims preparation section, it is screened for missing information. If either the provider name, provider number or the provider signature is missing, the claim is returned to the provider with a Return to Provider (RTP) Letter. The claim is not entered into the claims processing system. It is necessary for the provider to enter the missing information on the claim and return it to the original post office box for processing.

## 1.2 Processing of Claims

Each claim that passes the claims preparation screening is entered through an Optical Character Recognition (OCR) system and processed by HP Enterprise Services, LLC. Claims are analyzed and the status or disposition is determined. One of the following dispositions is assigned to a claim.

- Paid - Payment to the provider is approved in accordance with program criteria; or,
- Denied - Payment cannot be made because the information supplied indicates the claim does not meet program criteria unless additional information can be provided that would allow payment; or,
- Pending - The claim is put on 'hold' so an analyst can manually review it.

## 1.3 Payment Cycle

After each weekly payment cycle, providers who had claims processed in that cycle will receive at least one of the following in the mail or electronically from HP Enterprise Services, LLC:

- Remittance Advice - A computer-generated document that advises the provider as to the status/disposition of each claim processed in the last payment cycle.
- Check or EFT- The mechanisms to pay the amount due to the provider.
- There is a $10.00 charge for an additional copy of a remittance advice or a check that has been cashed by the provider.

## 1.4 Remittance Advice

The Remittance Advice (RA) is a computer-generated document showing the status and payment breakdown of all claims submitted to DMAP for processing. The Remittance Advice plays an important communications role between the provider, DMAP and HP Enterprise Services, LLC. It tells the provider whether the claims submitted for payment were paid, denied, rejected, or in process. It is designed to simplify your accounting by allowing accurate reconciliation of claims submission.

Once a week all claims completed in a daily cycle are processed through the financial cycle. The RA is produced at the time checks are issued. Checks are written to providers for payment of their claims. The accompanying Remittance Advice is produced explaining each provider's payment on a claim-by-claim basis. Only providers who have finalized claims in process (received and keyed into the system), financial transactions, or adjusted claims will receive an RA.

Aside from providing a record of transactions, the Remittance Advice is intended to assist providers in reconciling their DMAP accounts. The RA should be the first source of reference if there are questions regarding a particular claim. Refer to the Telephone Inquiry and Written Inquiry sections of the Billing Instructions for more information regarding questions on a particular claim.

It is necessary for the provider to retain all copies of the RA's to assist in keeping claims and payment records current. Also, this is the provider's only record of paid and denied claims.

The RA is also a status report that inventories the current status of active claims. Should a submitted claim not appear on the RA within four to six weeks after submission, resubmit an original claim form.

The Remittance Advice contains one or more of the following sections, depending on the claim(s) filed and the actions(s) taken on those claims:

- Banner Page
- Paid Claims
- Denied Claims
- Pending Claims
- Adjusted Claims
- Remaining Balance on Previous Adjustments
- Financial Items
- Earnings Data

The following sections describe each page of the Remittance Advice. Each page is described and a sample of that page follows each description. Each field on the RA page is numbered and can be matched to the numbered fields on the RA sample.

All pages of the RA contain the headings on the first page of the Remittance Sample on the following page. The first page of the RA is the Banner Page.

## 1.5 Banner Page

The Banner Page is the first page of the Remittance Advice and it presents a written message or messages to the provider. This message contains very important information related to DMAP changes or processing procedures.

## 1.6 RA Banner Page Example

```
PROV  0000123456                                DELAWARE MEDICAID REMITTANCE ADVICE          OLIVER FAMILY PRACTICE CLINIC
TAXONOMY: 261QA1903N                                       BANNER PAGE                                  RA #:  4378564854
SEQ NO:     1                                            RA DATE  06/30/1997                            PAGE:  1

                           THIS PAGE DISPLAYS IMPORTANT MESSAGES SUCH AS RECENT POLICY UPDATES, BILLING
                           CHANGES AND HOLIDAY SCHEDULES FOR DHSS & HP Enterprise Services, LLC. PLEASE READ THIS
INFORMATION
                           AND RETAIN FOR FUTURE REFERENCE. THIS INFORMATION MAY BE DISPLAYED FOR ALL
                           PROVIDERS OR FOR A SPECIFIC PROVIDER TYPE.

                                                                                     OLIVER FAMILY PRACTICE CLINIC
                                                                                     9945 E OLIVER
                                                                                     STE 445
                                                                                     WILMINGTON  DE 19809-0000
```

## 1.7 Claim Status

The Claim Status section includes the Paid Claims, Denied Claims, Pending Claims, and Adjusted Claims sections. The Claim Status prints in the left corner of the report section of the RA. This denotes where the section begins. (For example, Paid Claims in the upper left corner of the report section denotes where the Paid Claims section begins.) All of these sections have the same format unless noted otherwise in the description. The sample Paid Claims page that follows describes the elements found in the Paid Claims section of the RA. Use this page as a reference for the other three sections. A description of the elements unique to the Denied Claims, Adjusted Claims, and Claims In-Process sections is also provided following the Paid Claims section.

**Field Descriptions**

| Field | Description |
|---|---|
| PROV | This field indicates the unique number of the provider who is receiving the RA. . The provider number consists of 10 unique digits. |
| RA NUM | This field indicates the number of the RA for the provider for the current financial cycle. |
| RA TITLE | This field indicates the type of RA generated (i.e. Institutional/UB92). |
| TAXONOMY | The taxonomy codifies provider type and provider area of specialization for all medical related providers |
| SEQ NO | This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives a RA. The sequence number is reset at the beginning of each calendar year. |
| RA DATE | This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date. |
| PAGE NUM | The sequence number of this page of the report when compared to the total number of pages for this report. |
| CLAIM TYPE | This field indicates the claim type description for claims located in this section of the RA (inpatient, etc.). |
| CLIENT NAME | This group of two fields indicates the first five characters of the client's last name and the first three characters of the client’s first name. |
| MID | This field indicates the client’s unique Medicaid Identification (MID) number as it appears on the claim. |
| ICN | This field indicates the unique Internal Control Number (ICN) assigned to the claim. |
| VER | The version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments. |
| PT ACCT/RX # | This field indicates the client account or medical record number that appears on the claim. This field may also contain the prescription number if the provider bills pharmacy claims under the same provider number. |
| BILLED AMT | This field indicates the amount billed by the provider for service. |
| NON ALLOWED AMT | This field indicates the non-allowed amount for the claim. It is equal to the billed amount minus the allowed amount. |
| ALLOWED AMT | This field indicates the Medicaid allowed payment for the claim. |

| Field | Description |
|---|---|
| OI | This field indicates the amount paid by another insurance carrier for this claim. |
| COPAY AMT | This field indicates the portion of the billed amount for which client is responsible, if a co-payment is applicable to the client and/or the service. |
| PAID AMT | This field indicates the dollar amount included in the payment for the claim. The value is calculated as:<br>ALLOWED AMOUNT<br>- COPAY AMOUNT<br>- LIABILITY AMOUNT<br>- INSURANCE AMOUNT<br>PAID AMOUNT |
| HEADER EOB MESSAGES | These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA. |
| LIAB AMT | This field indicates the dollar amount for which the client is responsible. It is based on claim details. |
| DTL# | The detail number corresponds to the ICN and indicates the detail of the claim. |
| FDOS | This field indicates the first date the service was rendered as it appears listed on the claim. |
| TDOS | This field indicates the last date the service was rendered as it appears listed on the claim. |
| PROC | This field indicates the procedure code. |
| MOD | This optional field indicates the HCPCS code modifier as it appears on the claim. |
| UNIT SVC | This field indicates the units of service. |
| DETAIL EOB MESSAGES | These 10 fields relate to the message codes printed under the detail information. These numbers are the Explanation Of Benefit codes and indicate the reasons for payment or denial of the claim on the detail level (lower portion of the claim). The narrative descriptions for the Explanation of Benefit codes can be found in earnings data section of the RA. |
| CLAIM TOTAL | This field indicates the total of all claims for that claim type. |
| PAID CLAIMS TOTALS | This field indicates the total number of claims appearing in the paid claims section of the provider's RA. This value is equal to the sum of the claim type subtotals in the paid claims section of the RA. |

## 1.8 Paid Claims

The Professional Paid Claims section contains paid claim information for professional claims. Up to ten EOB codes are listed for each claim header and detail. The paid claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. With provider taxonomy, the claims are grouped by claim type and sorted by client last name. Subtotals are calculated for each claim type and a grand total is calculated for all claim types.

## 1.9 Professional Paid Claims RA Example

```
PROV:  0000123456                    DELAWARE MEDICAID MANAGEMENT INFORMATION SYSTEM                     JOSEPH SMITH, MD
TAXONOMY:  261QA1903N                                  PROFESSIONAL                                     RA #:  8875455978
RA SEQ NO: 1                                        RA DATE 06/30/1997                                  PAGE:  2

CLIENT NAME     MID           ICN      VER  PT ACCT/RX #   BLD AMT  NON ALLOWED  ALLOWED AMT     OI AMT  COPAY AMT   PAID AMT
HEADER EOB                                                             AMT                                  LIAB AMT
DTL#     FDOS     TDOS      PROC         MOD MOD2 MOD UNIT SVC
     DETAIL MESSAGES


P A I D  C L A I M S :
--------------------------------------------------------------------------------------------------------------------------------


CLAIM TYPE: PHYSICIAN
--------------------------

   DURAN  JOE 06575480000 111997160050010 00  05545878
 365
   01      06/06/97  06/06/97   99381                 1           59.00         6.57       52.43         28.60        0.00        23.83
      365                                                                                                                  0.00

   02      06/06/97  06/06/97   0100J                 3           15.00         6.00        9.00          0.00        0.00         9.00
                                                                                                                           0.00




               CLAIM TOTALS:                                      74.00        12.57       61.43        28.60         0.00        32.83
                                                                                                                           0.00

PREVIOUS BALANCE DUE: -0000       ADJUSTED AMOUNT THIS CYCLE: 0000         REMAINING BALANCE DUE: -000

TOTAL REMIANING BALANCE DUE: -00000
```

## 1.10 Pended Claims

This section lists those claims that have been entered into the system but have not reached final disposition. Please do not rebill a claim shown in this section as it is already in our system and will result in a denial as a duplicate claim. These claims will appear on subsequent RA's in this section until they are paid, denied or rejected.

The format of this section differs from the standard RA page as follows. The only valid amount field is the billed amount field. The Paid Amount, Total Allowed, Total Medicare Allowed Amount, Total Medicare Paid Amount, Total Deductible, Total TPL Amount, and the Total Status Amount fields are not included in this section as they are not relevant to pending claims.

The pended claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. Within provider taxonomy, the claims are grouped by claim type and sorted by client last name. Subtotals are calculated for each claim type and a grand total is calculated for all claim types.

## 1.11 Pending Claims RA Example

```
PROV #:     0000123456                              DELAWARE MEDICAID REMITTANCE ADVICE                     JOSEPH SMITH, MD
TAXONOMY:   261QA1903N                                         PROFESSIONAL                                RA #: :2215935645
RA SEQ NO: 1                                                RA DATE 06/30/1997                             PAGE:  4

CLIENT NAME     MID           ICN       VER  PT ACCT/RX # LD AMT   NON ALLOWED   ALLOWED AMT   OI AMT  COPAY AMT     PAID AMT
HEADER EOB                         .          AMT                                                      CLIENT    CONT AMT
DTL #       FDOS      TDOS     PROC  MOD MOD2 MOD3 UNIT SVC
      DETAIL EOB

                                      P E N D I N G   C L A I M S   D O   N O T   R E B I L L
-----------------------------------------------------------------------------------------------------------------------------
-----

CLAIM TYPE: CMS-1500
------------------------

 ALEXA RAN 0555786000 401997174248011 00

  01 06/15/1997  06/15/1997  0542P  31.68




 CLAIM TOTALS:                                                 31.68

 TOTALS FOR CLAIM TYPE: CMS-1500:          1 CLAIM(S)   31.68

 PENDING CLAIMS TOTALS:                    1 CLAIM(S)   31.68
```

## 1.12 Adjusted Claims

The Professional Adjusted Claim section contains adjusted claim information for professional adjusted claims. Up to ten EOB codes are listed for each claim header and detail. For each adjusted claim, the RA displays the original claim payment information along with the adjusted claim payment information. The original paid amount, refunds from provider amount, net adjustment amount, and a description of the adjustment reason code are included after each adjusted claim.

The adjusted claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. Within provider taxonomy, the adjusted claims are sorted by client last name. Grand totals are calculated for adjustment claim totals and total net adjustment amounts are calculated to reflect the net effect of all adjustments.

## 1.13 Professional Adjusted Claims RA Example

```
PROV #:     0000123456                        DELAWARE MEDICAID REMITTANCE ADVICE                              JOSEPH SMITH, MD
TAXONOMY:   261QA1903N                                    PROFESSIONAL                                         RA #: 3335458216
RA SEQ NO: 1                                           RA DATE 06/30/1997                                      PAGE: 5

CLIENT NAME     MID           ICN      VER  PT ACCT/RX #    BLD AMT  NON ALLOWED  ALLOWED AMT       OI AMT    COPAY AMT     PAID AMT
HEADER EOB                                                                 AMT                                  CLIENT CONT AMT
DTL #       FDOS      TDOS     PROC  MOD MOD2 MOD3 UNIT SVC
      DETAIL EOB


A D J U S T E D  C L A I M S
------------------------------------------------------------------------------------------------------------------------------------

 WINST BAI  0000000  0000997036222049  00  000111222  111

  01  02/03/1997  02/04/1997  0541P  64  173.44  0.00  173.44  0.00  0.00  173.44


      ORIGINAL CLAIM TOTALS:                          173.44  0.00  173.44  0.00  0.00  173.44

      ORIGINAL CLAIM - PAID DATE: 02/10/1997

 WINST BAI  0000000  001997148231050  01  000111222  111

  01  02/03/1997  02/04/1997  0541P  40  108.40  0.00  108.40  0.00  0.00  108.40


      ADJUSTED CLAIM TOTALS:                          108.40  0.00  108.40  0.00  0.00  108.40


 ADJUSTMENT DESCRIPTION: WRONG UNITS OF SERVICE
 ORIGINAL PAID AMT: 173.44  ADJUSTED PAID AMT: 108.40  REFUND FROM PROV: 64.04  NET ADJUSTMENT AMT: 0.00


      ADJUSTMENT CLAIM TOTALS:   1 CLAIM(S)  108.40  0.00  108.40  0.00  0.00  108.40


      TOTAL NET ADJUSTMENT AMOUNT:   0.00
```

## 1.14 Remaining Balance on Previous Adjustments

The Professional Remaining Balance on Previous Adjustments section contains adjusted claim information for previously adjusted, professional claims with outstanding balances. Up to ten EOB codes are listed for each claim header and detail. This section shows unsatisfied adjustments that were carried over from previous cycles that have had monies applied to them in the current cycle. For each previously adjusted claim, the RA displays only the adjusted claim payment information along with the previous balance, any money applied to the balance, and the remaining balance.

The previously adjusted claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. With provider taxonomy, the adjusted claims are sorted by client last name. A total remaining balance due is calculated to reflect the remaining balance of all previous adjustments.

## 1.15 Remaining Balance on Previous Adjustments RA Example

```
PROV:        0000123456                                   DELAWARE MEDICAID MANAGEMENT INFORMATION SYSTEM                 JOSEPH SMITH, MD
TAXONOMY:    261QA1903N                                               PROFESSIONAL                                     RA #:  5545876215
RA SEQ NO: 1                                                   RA DATE 06/30/1997                                       PAGE:  6

CLIENT NAME        MID          ICN       VER   PT ACCT/RX #  BILLED AMT  NON ALLOWED  ALLOWED AMT   OI AMT     COPAY AMT   PAID AMT
HEADER EOB                                                                 AMT                                   LIAB AMT
DTL#        FDOS      TDOS       PROC  MOD  MOD2  MOD3      UNIT SVC
     DETAIL MESSAGES


 R E M A I N I N G   B A L A N C E   O N   P R E V I O U S   A D J U S T M E N T S
------------------------------------------------------------------------------------------------------------------------------------

   JACKS  ULY 0000060000 2000997139238460 99 854562JAU
 368
   01      01/06/97    01/06/97    33870               1        3,800.00       392.10    3,407.90        0.00          0.00      3,407.90
                                                                                                                             0.00

              CLAIM TOTALS:                                     3,800.00       392.10    3,407.90        0.00          0.00      3,407.90
                                                                                                                             0.00

       PREVIOUS BALANCE DUE:     -2,228.60   ADJUSTED AMOUNT THIS CYCLE:    1,100.00     REMAINING BALANCE DUE:    -1,128..60


       TOTAL REMAINING BALANCE DUE:     -1,128.60
```

## 1.16 Earnings Data

The Remittance Advice - Earnings Data section contains a summary of provider earnings, both current and year to date. This information is calculated and shown at the provider level. The earnings section is separated by program and includes the month-to-date totals.

## 1.17 Earnings Data RA Example

```
PROV:         0000123456                   DELAWARE MEDICAID REMITTANCE ADVICE                               JOSEPH SMITH, MD
TAXONOMY:     261QA1903N                                                                                 RA NUM:  0544255455
RA SEQ NO:    1                                      RA DATE 06/30/1997                                  PAGE #    6

                                                                         CURRENT                       YEAR-TO-DATE

                        NUM OF PAID CLAIMS                                 426                             8,111

                        NUM OF DENIED CLAIMS                                21                                44

                        NUM OF PENDED CLAIMS                                 8

                        NUM OF ADJUSTED CLAIMS                              10                                17

                        NUM OF VOIDED CLAIMS                                 0                                 0

                        NUM OF CASE MAINTENANCE FEE CLAIMS                   0                             1,200

** WARRANT DATA **
                        CLAIMS PAID AMOUNT                           28,443.70                        405,550.66

                        INCREASE DUE TO CLAIM ADJUSTMENTS                12.60                             12.60
                        NON-CLAIM PAYOUT AMOUNT                           0.00                              0.00

                        RECOUPMENT AMOUNT WITHHELD                      -88.25                            -88.25
                        AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS       -374.11                           -866.35
                        LEIN, PENALTY, AND INTEREST WITHHELD              0.00                              0.00

                       *TOTAL WARRANT PAYMENT AMOUNT                 27,993.94                        408,808.66

** EARNINGS DATA **
                        NET EARNINGS (INCLUDES LEIN, PENALTY,
                        AND INTEREST WITHHELD AMT)                    28,443.70                        409,750.66

                        REFUNDS / RETURNED WARRANTS                       0.00                              0.00

                        OTHER ADJUSTMENTS                              -449.76                           -942.00

                        TOTAL  EARNINGS                        27,993.94                        408,808.66

 .

** MESSAGE CODES **

365 FEE ADJUSTED TO MAXIMUM ALLOWABLE
399 PROCEDURE REQUIRES PRIOR AUTHORIZATION
```

## 1.18 Resubmitting Claims

Denied claims may be resubmitted only if the provider can correct the information or refute the reason for which the claim was denied.

Claims and attachments should be mailed to the same post office box as an original claim.

Claims should be resubmitted only for the following reasons:

- If the claim has not appeared on your RA as paid, denied, rejected or in process after 30 days have elapsed from the date of original submission. You may submit a new original claim.

Claims and appropriate attachments should be mailed to the same post office box as an original claim. Resubmitted claims must conform to the timely filing guidelines that can be referenced in the General Policy Section of this manual.

- If the claim has been denied due to erroneous or missing information, a complete new claim form with corrected or added information must be submitted. The new claim form must be accompanied by a copy of the appropriate page of the original RA to prove timely filing and a copy of any necessary supporting documentation for example, DMAP eligibility verification). See NOTE below.

**Note: Whenever a new claim form is submitted for a claim that has been previously processed, a copy of the appropriate page of the original RA must be attached to the resubmitted claim to provide evidence that the original claim was filed within timely claim submission requirements. If the attachment is not present, the claim will be subjected to original timely claim filing restrictions.**

# 2.0 Adjustments

## 2.1 Adjusting a Paid Claim

It is the provider's responsibility to submit an Adjustment Request Form to HP Enterprise Services, LLC in the following situations:

- When a provider receives an incorrect payment
- Inaccurate claim information was submitted with the original claim.
- The provider has received payment from a third party source after Medicaid has made payment.

A separate Adjustment Request Form must be completed for each paid claim requiring an adjustment. Denied claims cannot be adjusted. They must be resubmitted as a new claim.

All Adjustment Request Forms must be submitted to the following address: Adjustments may be submitted electronically using the Provider Electronic Solutions billing software. Please refer to your manual for instructions on submitting adjustments.

HP Enterprise Services, LLC

P.O. Box 909, Manor Branch

New Castle, DE 19720-0909

Attn: Adjustments

## 2.2 Remittance Advice

An adjustment request is processed through the' claims system. It may result in an increase or a decrease in payment. Disposition of the processed request appears in the Adjusted Claims section on the Remittance Advice. Refer to the Remittance Advice section of the Billing Instructions in your manual for detailed information about the Adjusted Claims section of your Remittance Advice.

## 2.3 Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services provided to Medicare/Medicaid clients, notify the appropriate Medicare Fiscal Intermediary of your appeal. Once Medicare has adjusted the claim, complete an Adjustment Request Form and send it to HP Enterprise Services, LLC at the above address.

If payment has been made to an incorrect provider or if an overpayment has been made, return the erroneous check(s) or issue refunds to Medicare and to Medicaid for their respective shares.

Any erroneous Medicaid payments or refunds due must be attached to a completed Adjustment Request Form and sent to HP Enterprise Services, LLC at the above address.

## 2.4 Overpayment/Refund Adjustments

If an overpayment is made on a claim, it is the provider's responsibility to refund the overpayment amount by completing an Adjustment Request Form, clearly stating the specific reason for the overpayment. You may choose to void the claim by checking the “please void this claim” box in section 10 on the Adjustment Request form. This action causes the entire amount of the payment for this claim to be withheld from future claim payments

Refunds must also be made when a payment is received from a third party source after Medicaid has made payment on the claim. Refunds may be made in two ways: processing an adjustment request form and allowing any refund to be deducted from future Medicaid payments *or* by sending a refund check attached to a completed Adjustment Request Form. Make checks payable to HP Enterprise Services, LLC.

## 2.5 Adjustment Filing Limitation

A claim that has been paid may be adjusted up to two years from the date of service. Adjustments will be accepted beyond two years from the date of service in the following circumstances:

- Claim voids and positive adjustments (resulting in a lesser payment to the provider) may be submitted within five years from the date of payment.
- Claim voids and positive adjustments over 5 years from the date of payment may be submitted on a Medicaid Credit Balance Report (MCBR). Refer to the MCBR section of this manual for information related to the report.

## 2.6 Completion of the Adjustment Request Form

This Adjustment Request Form can be duplicated for use as needed. When making copies, it is not necessary to copy these instructions. Adjustment requests must be mailed. Please do not fax this form. If you bill electronically, please refer to your PES manual for instructions on submitting adjustments electronically.

1. Provider Medicaid Number: enter your 10-digit Medicaid provider number. Do not use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your remittance advice (RA).
2. Taxonomy – enter your taxonomy number located in the upper left hand corner of your RA.
3. Prov. Name: enter your provider name. This is in the lower right-hand corner of the first page of your RA.
4. Prov. Address: enter your mailing address. This is in the lower right-hand corner of the first page of your RA.
5. Claim ICN: This is the unique 15-digit claim identification

number. It is found on the Paid Claim page of your RA following the client's MID.

6. Client Medicaid Number (MID): enter the 10-digit client Medicaid Identification Number. It is found on the Paid Claim page of your RA following the client's name. Do not use a Social Security number.
7. Client Name: enter the client's name as it is on the RA. It is found on the Paid Claim page of your RA.
8. RA Number: This is in the upper right-hand corner of the first page of your RA.
9. RA Date: enter the date from the RA. This is at the top of the first page of your RA.
10. Correct Billing Information: simply and clearly state what the correct billing information should have been on the claim. If a line of a claim needs to be corrected, enter the line number from the claim form. Enter what was wrong on the line and the correct information to replace it.

    Example: a claim is incorrectly billed with 100 units on line 4 and, after the claim is submitted, the provider receives a check from other insurance. The correct number of units is 10 and the insurance amount is $1124.47. Complete the form as shown:

| Claim Line (optional) | Incorrect Information on Claim | Correct Information for Adjustment |
|---|---|---|
| 4 | 100 units billed | Correct number of units is 10 |
| | | Other insurance paid $1124.47 |

11. Requested Action: please check the appropriate box.
12. Signature: the person who completes this form must sign and date it.
13. Medicare Allowable: If this is an adjustment request to a Medicare crossover claim, enter the Medicare information.

This page intentionally left blank.

## 2.7 Adjustment Request Form

**Mail to:** **HP Enterprise Services, LLC**
P.O. Box 909
New Castle, DE 19720

**Information:** (800) 999-3371

# Adjustment Request Form

1. Provider Medicaid Number: ______________________________

2. Taxonomy______________________________________________

3. Prov. Name: __________________________________________

4. Prov. Address: ________________________________________

___________________________ ZIP _________

5. Claim ICN: ______________________________

6. Client Medicaid Number: __________________

7. Client Name: ____________________________

8. RA Number: _____________________________

9. RA Date: ________________________________

10. Correct Billing Information:

| Claim Line (optional) | Incorrect Information on Claim | Correct Information for Adjustment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

11. Requested Action:

☐ Please void this claim.

☐ Please withhold overpayment in a future Medicaid RA with an adjustment.

☐ Please pay me more in a future warrant due to an underpayment by Medicaid.

12. Signature: ____________________________________________________ Date: _______________

13.

If Medicare Allowable:
Medicare Allowed: ________________
Medicare Paid: ________________
Coinsurance: ________________
Deductible: ________________
Non-Covered: ________________

**HP Enterprise Services, LLC use only**
Comments:
HP Clerk Initials:
Date:___________________________________

This page intentionally left blank.

## 2.8 Change of Provider Information Authorization Form

The provider must submit changes to Provider enrollment information in writing (or via facsimile). The following form may be copied and used to submit provider enrollment change information. All requests for enrollment changes must be signed and dated.

<table>
<tr><td>Provider Number:</td><td>Provider Name:<br>Taxonomy:</td></tr>
<tr><td colspan="2">Date requested information is effective:</td></tr>
<tr><td colspan="2">Please change the information for the following name(s) or address(es):<br>______ Pay-to ______ Mail-to ______ Service Location(s)</td></tr>
<tr><td>Old Address:</td><td>New Address:</td></tr>
<tr><td>Old Telephone Number:</td><td>New Telephone Number:</td></tr>
<tr><td colspan="2">Additional Comments</td></tr>
<tr><td colspan="2">Provider Signature:<br>Date Signed:</td></tr>
</table>

**Mail to:** **HP Enterprise Services, LLC**
Provider Enrollment
P.O. Box 909
New Castle, DE 19720

**Fax to:** **HP Enterprise Services, LLC**
Attn. Provider Enrollment
(302) 454-7603

**Information:**(800) 999-3371

This page intentionally left blank.

## 2.9 Affiliation Roster

Individual providers must use this roster to affiliate with a group (or groups) already enrolled in the Delaware Medical Assistance program. Providers must be enrolled as individuals before they can be affiliated with a group. Being included in a group enrollment does not enroll the individual with Medicaid.

Do not complete this page if you are an individual provider not affiliated with a group practice.

NOTE: Listing a group on this form does not enroll the group in the Delaware Medical Assistance Program.

NOTE: The individual provider must sign and date this sheet. No other person can be authorized to sign for an individual provider.

| Group Name | Delaware Medicaid Group Provider Number | Taxonomy | Date Signed | Date Effective |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I wish to be affiliated with the above listed group(s) in the Delaware Medical Assistance Program.

Signature: ______________________________________________

Name typed or printed: ______________________________________

Individual Provider Medicaid number: __________________________

Date: ________________

**Mail to:** **HP Enterprise Services, LLC**
Provider Enrollment
P.O. Box 909
New Castle, DE 19720

**Fax to:** **HP Enterprise Services, LLC**
Attn. Provider Enrollment
(302) 454-7603

**Information:** (800) 999-3371

This page intentionally left blank.

# 3.0 Written Inquiry

HP Enterprise Services, LLC has a Provider Services Unit available to answer written inquiries concerning claims processing. Responses to written inquiries should be kept as documentation for future reference, or as support of timely filing requirements.

## 3.1 General Information

To expedite the handling of claim inquiries, HP Enterprise Services, LLC requires the use of the Provider Inquiry Form. Include as much information as possible on the form and attach any documentation you feel is necessary to explain your inquiry. Inquiries can also be submitted electronically through the state web site: www.dmap.delaware.de.us. If mailing written inquiries, please use the address below:

HP Enterprise Services, LLC
P.O. Box 909, Manor Branch
New Castle, DE 19720-0909
Attn: Provider Services Unit

## 3.2 Completion of the Provider Inquiry Form

To ensure proper resolution of your inquiry, please complete the inquiry form accurately and legibly. **Use a separate form for each inquiry**. A sample copy of the Written Inquiry form follows this section for your reference. The form will be a 3-part carbonless form. The white and yellow copies are to be forwarded to HP Enterprise Services, LLC. **The pink copy is for your records**. HP Enterprise Services, LLC will respond to your inquiry on the yellow copy of the form.

| Field Number | Description | Instructions for Completion |
|---|---|---|
| 1 | Provider Return Name and Address | Please type or print legibly the provider’s complete name and address. The inquiry response will be returned to the provider in a window envelope. |
| 2 | Claim Explanation Requested | Check the appropriate box to indicate your request for explanation. (DHSS = Department of Health and Social Services, TPL = Third Party Liability) |
| 3 | Client Name | Enter the client's name exactly as it appears on the Medicaid Identification card. |
| 4 | Client Number | Enter the complete ten-digit client Medicaid identification number as listed on the Medicaid card. |
| 5 | Dates of Service | Enter the complete dates of service that reflect the start and end dates of service rendered on the original claim in question. |
| 6 | Remittance Advice Date | Enter the date of the Remittance Advice on |

| Field Number | Description | Instructions for Completion |
|---|---|---|
| | | which the services appeared, if applicable. |
| 7 | Amount Billed | Enter the dollar amount that was billed for the service rendered |
| 8 | Amount Paid | Enter the dollar amount that was paid for the service rendered. |
| 9 | RX Number (Pharmacy Only) | Enter the prescription number that relates to your inquiry. |
| 10 | NDC (Pharmacy Only) | Enter the NDC that relates to your inquiry |
| 11 | Claim Number or ICN | If the services rendered have appeared on a Remittance Advice (RA), enter the 15-digit claim number (Internal Control Number, ICN) assigned by HP Enterprise Services, LLC exactly as it appears on your RA. |
| 12 | Specific Description | Describe as specifically as possible the nature of your inquiry. Attach any supporting documentation that may be of assistance in resolving your inquiry. |
| 13 | Signature of Sender | The provider or designated authorized individual must sign and date the Provider Inquiry Form. "Provider's Signature" is defined as the provider's actual signature or the signature of an individual authorized by the provider. The name of a clinic or group is not acceptable. |
| 14 | Date | Enter the date of your inquiry. |
| 15 | Medicaid Billing Provider Number | Enter the entire ten-digit Delaware Medicaid Billing Provider number. |
| 16 | Phone | Enter the phone number (including area code) of someone we can contact with questions regarding this inquiry. |

## 3.3 Provider Inquiry Form

# Provider Inquiry Form

**EDS**

EDS Corporation
P.O. Box 909 Manor Branch
New Castle, DE 19720-909
ATTN: Provider Relations

1. Provider Return Name & Address:

2. Claim Explanation Requested:

☐ Amount Paid ☐ Status of Claim ☐ Denial of Claim ☐ DHSS Eligibility Review ☐ TPL Update

☐ Resubmit My Claim; Reply Requested ☐ Other (Please Explain) __________

3. Client Name __________ 4. Client Number __________

5. Date of Service __________ 6. Remittance Advice Date __________

7. Amount Billed __________ 8. Amount Paid __________

9. RX Number (Pharmacy Only) __________ 10. NDC (Pharmacy Only) __________

11. Claim Number __________ 12. Please give a specific description of the problem: __________

13. Signature of Sender __________ 14. Date __________

15. Medicaid Billing Provider Number __________ 16. Phone ( ) __________

EDS Response:

☐ Your claim was submitted for processing: ☐ on __________. ☐ today.

☐ Your claim # __________ was paid on __________ in the amount of $ __________.

☐ EDS can find no record of this claim. Please resubmit claim with an original ink signature.

☐ Your claim does not meet timely filing guidelines. Please refer to the General Policy section of your Provider Manual for timely filing guidelines.

☐ Please sign your claim with an original ink signature and resubmit.

☐ Please do not resubmit your claim # __________. It is currently pending

☐ Other: __________

EDS Representative Signature __________ Date of Reply __________

This page intentionally left blank.

# 4.0 Telephone Inquiry

## 4.1 Provider Telephone Inquiry

HP Enterprise Services, LLC has a Provider Services Unit available to answer telephone inquiries. Provider service representatives are available Monday through Friday, 8:00 am until 5:00 pm (Eastern Time). The following telephone number can be used to contact the Provider Services staff at:

Toll-free - 1-800-999-3371

Including Delaware, Maryland, New Jersey & Pennsylvania

When calling the Provider Services Unit, it is important to have such information as provider number, client ID number and dates of service readily available. If your inquiry cannot be answered at the time of your phone call, all necessary information will be taken and a return call made to you as soon as possible.

This page intentionally left blank.

# 5.0 Ordering Forms

The following forms can be ordered through HP Enterprise Services, LLC:

- Pharmacy Claim Form (pin-fed/continuous feed)
- Written Inquiry Form
- Awareness Form
- Consent Form
- Adjustment Request From

These forms are free of charge. To obtain these claim forms, access the State Web site: www.dmap.delaware.de.us or use the orders form on the following page. The order form can be copied and used whenever more forms are needed. The CMS-1500, ADA Dental and UB-04 universal claim forms are not supplied by HP Enterprise Services, LLC but can be ordered through a local business forms supplier.

## 5.1 Completion of the Order Form

A sample copy of the Order Form is included for your reference. The form should be completed as follows.

| Field Number | Description | Instructions for Completion |
|---|---|---|
| 1 | Provider Address | Enter your provider name and address. Your complete and correct mailing address including a zip code for proper deliver. Also, complete the ATTN: line in order for the forms to be delivered to you. |
| 2 | Provider Identification Number | Enter the Medicaid provider number assigned to you. |
| 3 | Forms | Indicate the quantity of forms you are requesting. You may also indicate if you would like to request a Provider Manual. |
| 4 | Mail to Address | Mail your completed form to HP Enterprise Services, LLC at the address located on the form. |

This page intentionally left blank.

## 5.2 DMAP Order Form

HP Enterprise Services, LLC-supplied forms (see list of available forms in Section 5.0) can be ordered from HP Enterprise Services, LLC by completing this order form and sending it to address shown below. The quantity of the form request and all provider information should be completed to ensure that the order is filled correctly. Providers can also obtain these claim forms by accessing the State Web site at www.dmap.delaware.de.us

**Provider Information**

| Provider Name | |
|---|---|
| Provider Street Address | |
| | |
| City, State and ZIP Code | |
| Attention: | |
| DMAP 10-digit Provider# | |

**Form Request**

| **Form** | **Quantity of Form** | | | | |
|---|---|---|---|---|---|
| | 25 | 50 | 100 | 250 | 500 |
| Pharmacy Claim Form | | | | | |
| Written Inquiry Form | | | | | |
| Awareness Form | | | | | |
| Consent Form | | | | | |
| Adjustment Request Form | | | | | |

Mail the completed form to:

HP Enterprise Services, LLC

P.O. Box 909, Manor Branch

New Castle, DE 19720-0909

Attention: Processing Control Unit

This page intentionally left blank.

# 6.0 Electronic Claims Submission

## 6.1 General Information

Provider Electronic Solutions is available for any DMAP provider who has compatible data processing equipment or who can contract for data processing services. ECS has many benefits including:

- Payment of claims can be quicker
- Reduction of clerical effort in your office
- Significant improvement in your cash flow
- No manual intervention
- Costs to the provider should decrease and

## 6.2 Methods of Submission

The method of electronic billing is modem transmission to our clearinghouse – Electronic Commerce Management System (ECMS).

## 6.3 How to Submit Claims Electronically

There are three methods of how claims can be submitted electronically. They are:

- Clearinghouse - A clearinghouse collects claims at a central office from many providers and sends claims electronically to our clearinghouse – Electronic Commerce Management System (ECMS).
- Vendor - A vendor who has created a Medicaid electronic billing software package installs this in the provider's computer. The provider would transmit the claim to our clearinghouse – Electronic Commerce Management System (ECMS).
- HP Enterprise Services, LLC Software - HP Enterprise Services, LLC can provide software, at no cost, to bill DMAP claims. The following minimum requirements must be met to use the software:

| Minimum | Recommended |
|---|---|
| Windows 95/98 | Windows 2000 or Windows NT |
| 64 Megabytes RAM | 128 Megabytes RAM |
| 800 x 600 Resolution | 1024 x 768 Resolution |
| 9600 Baud Rate Modem or faster is preferred | 9600 Baud Rate Modem or faster |
| CD-ROM is preferred | CD-ROM |
| Printer is preferred | Printer is preferred |

## 6.4 Contact Address and Telephone Number

If you are interested in submitting your claims electronically or would like more information, contact the ECS Coordinator at HP Enterprise Services, LLC by mail at:

HP Enterprise Services, LLC
P.O. Box 909, Manor Branch
New Castle, DE 19720-0909
Attn: ECS Coordinator

or by telephone at (302) 454-7622