NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Billing for Non-Emergency Medical Transportation (NEMT)

This information applies when billing Nebraska Medicaid for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid. Medicaid eligibility may be verified from:

1. The client's permanent Nebraska Medicaid Identification Card or temporary Nebraska Medicaid Presumptive Eligibility Application. For explanation and examples, see 471-000-123.
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124.
3. The **Medicaid Claims Customer Service line at 877-255-3092, Option #1**; or in Lincoln 402-471-9128.

The CMS 1500 (version 02-12) Health Insurance Claim Form must be used to submit NEMT claims. Please note that the form shown in this document is a **sample only and may not be used to submit claims**. The CMS-1500 claim form may be purchased from the U.S. Government Printing Office or from private vendors.

RETENTION OF RECORDS

For audit purposes, please be sure to retain records of all trips to support your billing.

CMS-1500 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims, retain a duplicate copy and mail the ORIGINAL form to:

Medicaid Claims Unit
Division of Medicaid and Long-Term Care
Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Form Completion Instructions: ALL following fields must be completed. The numbers listed below correspond to the numbers of the fields on the form. On the sample claim form these fields are highlighted in yellow. If you have additional questions after completing the form using these instructions, please contact the **Medicaid Claims Customer Service line at 877-255-3092, Option #1**; or in Lincoln 402-471-9128.

1a. INSURED'S I.D. NUMBER: Enter the Medicaid client's complete eleven-digit identification number (Example: 123456789-01).

2. PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

21. ICD INDICATOR: Enter '0'.

21A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Enter 'R69'.

24A. DATE(S) OF SERVICE: Enter the six-digit numeric date of service rendered (Example: 02-14-69). Each procedure code/service billed requires a date. The "From" date of service must be completed. The "To" date of service may be left blank.

24B. PLACE OF SERVICE: Enter '41'.

24D. PROCEDURES, SERVICES, OR SUPPLIES: In the unshaded area, enter the appropriate procedure code and, if needed, the procedure code modifier.

Guidance and definitions are listed in 471-000-503. Procedure codes and rates are available here.

Procedure Code Modifier: The modifier 52 indicated on the fee schedule for procedure code T2003 is used for trips not wholly within the corporate city limits of Lincoln or Omaha.

24E. DIAGNOSIS POINTER: Enter 'A' (This references the primary diagnosis from Field 21A).

24F. CHARGES: Enter the charge for each procedure code. Each procedure code must have a separate charge, on a separate line.

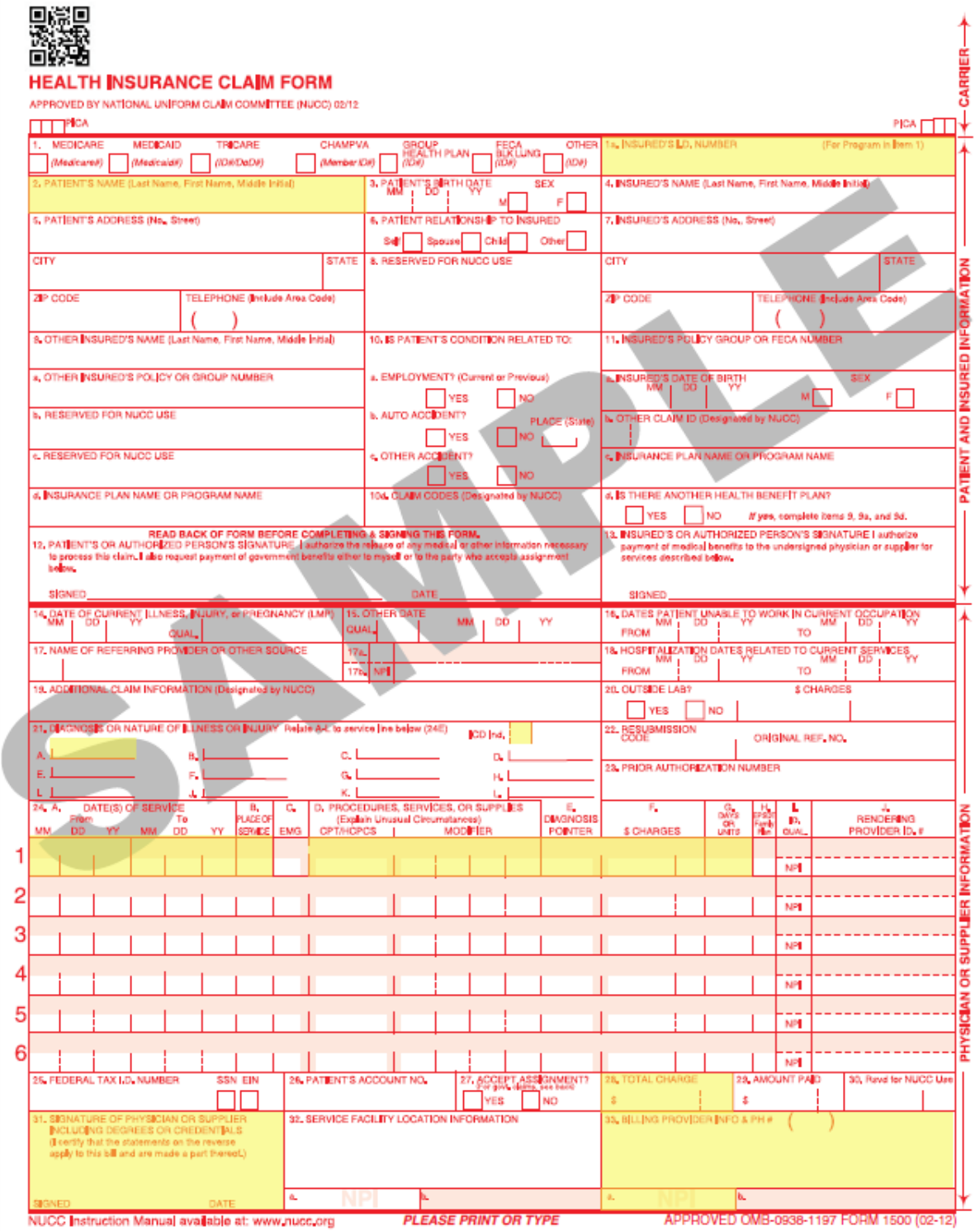
24G. DAYS OR UNITS: Enter the mileage or number of trips for each date of service.

28. TOTAL CHARGE: Enter the total of all charges in Field 24F.

31. SIGNATURE OF SUPPLIER: The provider or authorized representative must SIGN and DATE the claim form. A signature stamp, computer generated or typewritten signature will be accepted. The signature date must be on or after the dates of service listed on the form.

33. BILLING PROVIDER INFO & PHONE #: Enter the provider's name, address, nine-digit zip code (zip+4 as reported to Nebraska Medicaid), and phone number.

33a. Enter the <u>11-DIGIT MEDICAID PROVIDER NUMBER</u> of the Billing Provider as assigned upon enrollment with Medicaid.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)