APPENDIX 7
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR AODA DAY TREATMENT SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "M" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) When the recipient's Medical Assistance identification card indicates Medicare coverage, enter Medicare disclaimer code "M-8," since AODA day treatment is not a Medicare benefit.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.

- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service.

Code	Description
2	outpatient hospital
3	office

ELEMENT 24C - TYPE OF SERVICE CODE
Enter type of service code "1."

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. The procedure codes for AODA day treatment are listed below:

Code	Description
W8980	AODA Day Treatment Assessment (up 3 hours per calendar year)
W8981	AODA Day Treatment Assessment (annual 3-hour limitation exceeded; requires prior authorization)
W8982	AODA Day Treatment (requires prior authorization)

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed on each line item. All AODA day treatment services are one hour procedure codes. When billing for fractions of an hour, indicate units of service in half-hour increments using the standard rules of rounding.)

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as the result of a HealthCheck (EPSDT) referral.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.