

Chapter 12

Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

Revision:

Due to the size of [Figure 12.P-1](#), please go to the next page.

Chapter 12, Addendum P

FIGURE 12.P-1 REQUEST FOR ANTICIPATED PAYMENT (RAP) - NON-TRANSFER SITUATION

NUBC[®] National Uniform
Billing Committee LIC9213257

Chapter 12, Addendum P

FIGURE 12.P-2 RAP - NON-TRANSFER SITUATION WITH LINE ITEM SERVICE ADDED

Your Agency Name										32										3 TYPE OF BILL																			
Address																				322																			
City										ST Zip										5 FED TAX NO																			
										6 STATEMENT FROM										COVERS PERIOD THROUGH																			
										10012000										10012000																			
8 PATIENT NAME										a Doe Jane M										9 PATIENT ADDRESS																			
										b 123 Main Street										Anywhere ST 30000																			
10 BIRTHDATE										11 SEX										12 DATE										ADMISSION									
03151920										R										10012000										1									
31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE										34 OCCURRENCE DATE									
35 OCCURRENCE DATE										36 OCCURRENCE DATE										37 OCCURRENCE DATE										38 OCCURRENCE DATE									
41 CODE										VALUE CODES AMOUNT										42 CODE										VALUE CODES AMOUNT									
a 61										1900 00										b										c									
c																				d																			
43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV DATE										46 SERV UNITS									
0023 HH Services										HAEJ1										10012000										0 00									
0550 Skilled Nurse Visit																				10012000										150 00									
0001																														150 00									
PAGE										OF										CREATION DATE										TOTALS									
50 PAYER										51 HEALTH PLAN ID										52 REL INFO										53 ASG BEN									
A Medicare										167999										Y																			
58 INSURED'S NAME										59 PREL										60 INSURED'S UNIQUE ID										61 GROUP NAME									
A Doe, Jane M																				123456789A										62 INSURANCE GROUP NO.									
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																			
A 200010012000093001																																							
66 1629																														68									
69 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 ECI									
74 PRINCIPAL PROCEDURE CODE										75 OTHER PROCEDURE CODE										76 ATTENDING NPI										A12345									
																				LAST Green										FIRST Mark									
77 OPERATING NPI										78 OTHER NPI										79 OTHER NPI																			
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80 REMARKS										BTCC										81 OTHER NPI										QUAL									
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										b										79 OTHER NPI										QUAL									
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UB-04 CMS-1450										APPROVED OMB NO.										THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF																			

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-3 RAP - TRANSFER SITUATION

Note: Source of Admission [Form Locator (FL) 15] is a B, which indicates that this beneficiary transferred to your HHA from another HHA.

1 Your Agency Name Address City ST Zip		2		3a PAT. CNTL. # b MED. REC. #		4 TYPE OF BILL 322	
5 FED. TAX NO.		6 STATEMENT FROM 10162000		7 COVERS PERIOD THROUGH 10162000			
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000					
10 BIRTHDATE 03151920		11 SEX F		12 DATE OF ADMISSION 10162000		13 TYPE OF ADMISSION B	
14 SRC 30		15 DRG 30		16 STAT B		17	
18		19		20		21	
22		23		24		25	
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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-4 RAP - DISCHARGE/RE-ADMIT

Source of Admission (FL 15) is a C, which indicates that this beneficiary was discharged from your HHA, but was readmitted within the same 60-day episode.

1 Your Agency Name Address City ST Zip										2 3a PAY CNTL # b. MED REC # 5 FED. TAX NO										6 STATEMENT COVERS PERIOD FROM 10162000 THROUGH 10162000										7 8 TYPE OF SERVICE 3X2																																																																															
8 PATIENT NAME a Doe Jane M										9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000										c										d										e																																																																					
10 BIRTHDATE 03151920										11 SEX F										12 DATE OF ADMISSION 10162000										13 HR										14 TYPE C										15 SRC 30										16 DRG										17 STAT										18 19 20 21										22 23 24 25 26 27 28										29 ACCT STATE									
31 OCCURRENCE DATE										32 OCCURRENCE CODE										33 OCCURRENCE DATE										34 OCCURRENCE CODE										35 OCCURRENCE DATE										36 OCCURRENCE CODE										37 OCCURRENCE DATE										38 OCCURRENCE CODE										39 OCCURRENCE DATE										40 OCCURRENCE CODE																			
41 CODE										42 VALUE CODES AMOUNT										43 CODE										44 VALUE CODES AMOUNT										45 CODE										46 VALUE CODES AMOUNT										47 CODE										48 VALUE CODES AMOUNT										49 CODE										50 VALUE CODES AMOUNT																			
43 REV CD										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHANGES										48 NON-COVERED CHANGES										49																																							
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FIGURE 12.P-5 RAP - CANCELLATION

Note: The Type of Bill (TOB) changes to end in an 8, a Claim Change Reason Code (e.g., D5) is included, and the RHHI's Internal Control Number (ICN) that identified the original RAP is included.

1 Your Agency Name Address City ST Zip		2		3a PAT. CNTRL. # b. MED. REC. #		4 TYPE OF BILL 328	
5 FED. TAX NO.		6 STATEMENT FROM 10012000		7 COVERS PERIOD THROUGH 10012000			
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000					
b		c					
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000		13 ADMISSION 13 HR 14 TYPE 15 SRC C	
16 DRG 30		17 STAT D5		18		19	
20		21		22		23	
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560		561		562		563	
564		565		566		567	
568		569		570		571	
572		573		574		575	
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580		581		582		583	
584		585		586		587	
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592		593		594		595	
596		597		598		599	
600		601		602		603	
604		605		606		607	
608		609		610		611	
612		613		614		615	
616		617		618		619	
620		621		622		623	
624		625		626		627	
628		629		630		631	
632		633		634		635	
636		637		638		639	
640		641		642		643	
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648		649		650		651	
652		653		654		655	
656		657		658		659	
660		661		662		663	
664		665		666		667	
668		669		670		671	
672		673		674		675	
676		677		678		679	
680		681		682		683	
684		685		686		687	
688		689		690		691	
692		693		694		695	
696		697		698		699	
700		701		702		703	
704		705		706		707	
708		709		710		711	
712		713		714		715	
716		717		718		719	
720		721		722		723	
724		725		726		727	
728		729		730		731	
732		733		734		735	
736		737		738		739	
740		741		742		743	
744		745		746		747	
748		749		750		751	
752		753		754		755	
756		757		758		759	
760		761		762		763	
764		765		766		767	
768		769		770		771	
772		773		774		775	
776		777		778		779	
780		781		782		783	
784		785		786		787	
788		789		790		791	
792		793		794		795	
796		797		798		799	
800		801		802		803	
804		805		806		807	
808		809		810		811	
812		813		814		815	
816		817		818		819	
820		821		822		823	
824		825		826		827	
828		829		830		831	
832		833		834		835	
836		837		838		839	
840		841		842		843	
844		845		846		847	
848		849		850		851	
852		853		854		855	
856		857		858		859	
860		861		862		863	
864		865		866		867	
868		869		870		871	

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Chapter 12, Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-6 CLAIM - NON-TRANSFER SITUATION

1 Your Agency Name		2		3a PAT CNTL #		3b MED REC #		3c TYPE OF BILL	
Address		City ST Zip		5 FED. TAX NO		6 STATEMENT FROM		7 COVERS PERIOD THROUGH	
						10012000		11292000	
8 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street		Anywhere ST 50000	
b		b		c		d		e	
10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE	
03151920		F		10012000		1		30	
15 SRC		16 DRG		17 STAT		18		19	
20		21		22		23		24	
25		26		27		28		29 ACCT	
								30 STATE	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE	
36 OCCURRENCE FROM		37 OCCURRENCE THROUGH		38 OCCURRENCE FROM		39 OCCURRENCE THROUGH		40 OCCURRENCE FROM	
41 CODE		42 VALUE CODES AMOUNT		43 CODE		44 VALUE CODES AMOUNT		45 CODE	
61		1900 00							
a		b		c		d		e	
46 REV CD		47 DESCRIPTION		48 HCPCS / RATE / HIPPS CODE		49 SERV DATE		50 SERV UNITS	
0023		HH Services		HAEJ1		10012000		0 00	
0550		Skilled Nurse Visit		G0154		10012000		2 150 00	
0570		HH Aide		G0156		10012000		3 75 00	
0550		Skilled Nurse Visit		G0154		10102000		2 150 00	
0570		HH Aide		G0156		10102000		2 75 00	
0420		Physical Therapy		G0151		10152000		3 200 00	
0550		Skilled Nurse Visit		G0154		10202000		2 150 00	
0570		HH Aide		G0156		10202000		2 75 00	
0420		Physical Therapy		G0151		10252000		3 200 00	
0550		Skilled Nurse Visit		G0154		10302000		2 150 00	
0570		HH Aide		G0156		10302000		2 75 00	
0420		Physical Therapy		G0151		11042000		3 200 00	
0550		Skilled Nurse Visit		G0154		11102000		1 150 00	
0570		HH Aide		G0156		11102000		2 75 00	
0420		Physical Therapy		G0151		11142000		3 200 00	
0550		Skilled Nurse Visit		G0154		11202000		2 150 00	
0570		HH Aide		G0156		11202000		3 75 00	
0420		Physical Therapy		G0151		11242000		3 200 00	
0550		Skilled Nurse Visit		G0154		11292000		2 150 00	
0570		HH Aide		G0156		11292000		2 75 00	
0270		Supplies				11		132 58	
0001						43		2707 58	
PAGE		OF		CREATION DATE		TOTALS			
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS	
A Medicare		167999		Y					
55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID		58		59	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
A Doe, Jane M				123456789A					
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66		67	
A 200010012000093001									
68		69		70		71		72	
1629									
73		74		75		76		77	
78		79		80		81		82	
83		84		85		86		87	
88		89		90		91		92	
93		94		95		96		97	
98		99		100		101		102	

UB-04 CMS-1450

APPROVED OMB NO.

NUBC[®] National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-7 CLAIM - TRANSFER SITUATION - BENEFICIARY TRANSFERS TO YOUR HHA

Note: Source of Admission (FL 15) is a B, which indicates that this beneficiary transferred to your HHA from another HHA.

1 Your Agency Name Address City ST Zip		3a PAT CNTRL # 3b MED REC #		4 TYPE OF BILL 329	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 10012000 THROUGH 11292000		7	
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000			
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000	
13 HR		14 TYPE B		15 SRC 30	
16 DRG		17 STAT		18	
19		20		21	
22		23		24	
25		26		27	
28		29		30	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE	
34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE CODE DATE	
37		38		39	
40		41		42	
43		44		45	
46		47		48	
49		50		51	
52		53		54	
55		56		57	
58		59		60	
61		62		63	
64		65		66	
67		68		69	
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100		101		102	
103		104		105	
106		107		108	
109		110		111	
112		113		114	
115		116		117	
118		119		120	
121		122		123	
124		125		126	
127		128		129	
130		131		132	
133		134		135	
136		137		138	
139		140		141	
142		143		144	
145		146		147	
148		149		150	
151		152		153	
154		155		156	
157		158		159	
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226		227		228	
229		230		231	
232		233		234	
235		236		237	
238		239		240	
241		242		243	
244		245		246	
247		248		249	
250		251		252	
253		254		255	
256		257		258	
259		260		261	
262		263		264	
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466		467		468	
469		470		471	
472		473		474	
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526		527		528	
529		530		531	
532		533		534	
535		536		537	
538		539		540	
541		542		543	
544		545		546	
547		548		549	
550		551		552	
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739		740		741	
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763		764		765	
766		767		768	
769		770		771	
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781		782		783	
784		785		786	
787		788		789	
790		791		792	
793		794		795	
796		797		798	
799		800		801	
802		803		804	
805		806		807	
808		809		810	
811		812		813	
814		815		816	
817		818		819	
820		821		822	
823		824		825	
826		827		828	
829		830		831	
832		833		834	
835					

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Chapter 12, Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-8 CLAIM - SIGNIFICANT CHANGE IN CONDITION (SCIC) SITUATION

Note: Two HIPPS Codes appear on this claim due to a SCIC.

1 Your Agency Name		2		3a PAY CNTL #		3b MED REC #		3c TYPE OF PPS	
Address		City		ST		Zip		329	
4 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street		Anywhere ST 30000	
10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE	
03151920		F		10012000		1		30	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE	
36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH			
38		41 CODE		41 VALUE CODES AMOUNT		41 CODE		41 VALUE CODES AMOUNT	
		61		1900 00					
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV DATE		46 SERV UNITS	
1 0023		HH Services		HAEJ1		10012000		0 00	
2 0023		HH Services		HBFJ4		11102000		0 00	
3 0550		Skilled Nurse Visit		G0154		10012000		2 150 00	
4 0570		HH Aide		G0156		10012000		2 75 00	
5 0550		Skilled Nurse Visit		G0154		10102000		2 150 00	
6 0570		HH Aide		G0156		10102000		2 75 00	
7 0420		Physical Therapy		G0151		10152000		3 200 00	
8 0550		Skilled Nurse Visit		G0154		10202000		2 150 00	
9 0570		HH Aide		G0156		10202000		2 75 00	
10 0420		Physical Therapy		G0151		10252000		3 200 00	
11 0550		Skilled Nurse Visit		G0154		10302000		2 150 00	
12 0570		HH Aide		G0156		10302000		2 75 00	
13 0420		Physical Therapy		G0151		11042000		3 200 00	
14 0550		Skilled Nurse Visit		G0154		11102000		1 150 00	
15 0570		HH Aide		G0156		11102000		2 75 00	
16 0420		Physical Therapy		G0151		11142000		3 200 00	
17 0550		Skilled Nurse Visit		G0154		11202000		2 150 00	
18 0570		HH Aide		G0156		11202000		3 75 00	
19 0420		Physical Therapy		G0151		11242000		3 200 00	
20 0550		Skilled Nurse Visit		G0154		11292000		2 150 00	
21 0270		Supplies						11 132 58	
22 0001								43 2632 58	
23		PAGE OF		CREATION DATE		TOTALS			
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS	
A Medicare		167999		Y					
58 INSURED'S NAME		59 PREL 60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.			
A Doe, Jane M		123456789A							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME					
A 200010012000093001									
66 1629									
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE		74 OTHER PROCEDURE CODE		74 OTHER PROCEDURE CODE		74 OTHER PROCEDURE CODE		74 OTHER PROCEDURE CODE	
76 ATTENDING NPI		76 ATTENDING QUAL		77 OPERATING NPI		77 OPERATING QUAL		78 OTHER NPI	
A A12345		Mark							
78 OTHER QUAL		78 OTHER QUAL		79 OTHER NPI		79 OTHER QUAL		79 OTHER QUAL	
80 REMARKS		81 CC a		81 CC b		81 CC c		81 CC d	

NUBC National Uniform Billing Committee LIC9213257

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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-9 CLAIM - NO-RAP-LOW UTILIZATION PAYMENT ADJUSTMENT (LUPA) CLAIM

In this example, the beneficiary transferred to another HHA. Your HHA provided two services and had not yet submitted the RAP when the beneficiary transferred; therefore, you have a No-RAP-LUPA Claim situation.

1 Your Agency Name Address City ST Zip										2										3a PAT. CNTL. # b MED. REC. # 5 FED. TAX NO										4 TYPE OF BILL 329																																																																																																																																																																																			
6 STATEMENT FROM 10012000										7 COVERS PERIOD THROUGH 10032000																																																																																																																																																																																																							
8 PATIENT NAME a Doe Jane M										9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000																																																																																																																																																																																																							
10 BIRTHDATE 03151920										11 SEX F										12 DATE 10012000										13 HR 1										14 TYPE 06										15 SRC										16 DRG										17 STAT										18										19										20										21										22										23										24										25										26										27										28										29 ACOT										30 STATE									
31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE										34 OCCURRENCE DATE										35 CODE										OCCURRENCE SPAN FROM THROUGH										36 CODE										OCCURRENCE SPAN FROM THROUGH										37																																																																																																																																	
38										41 CODE										VALUE CODES AMOUNT										42 CODE										VALUE CODES AMOUNT										43 CODE										VALUE CODES AMOUNT																																																																																																																																																					
42 REV CD										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																																																																																																																											
0023										HH Services										HAEJ1										10012000										2										01 00																																																																																																																																																															
0550										Skilled Nurse Visit										G0154										10012000										3										150 00																																																																																																																																																															
0570										HH Aide										G0156										10012000										3										75 00																																																																																																																																																															
0001																														5										225 00																																																																																																																																																																									
PAGE 1 OF 1										CREATION DATE										TOTALS																																																																																																																																																																																													
50 PAYER										51 HEALTH PLAN ID										52 REL INFO										53 ASG BEN										54 PRIOR PAYMENTS										55 EST. AMOUNT DUE										56 NPI										57 OTHER PRV ID																																																																																																																																											
A Medicare										167999										Y																																																																																																																																																																																													
58 INSURED'S NAME										59 PREL										60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																																																																																																																																																																									
A Doe, Jane M																				123456789A																																																																																																																																																																																													
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																																																																																																																																																													
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UB-04 CMS-1450

APPROVED OMB NO.

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-10 CLAIM ADJUSTMENT

The TOB changes to end in a 7, a Claim Change Reason Code (e.g., D9) is included, and the RHHI's ICN that identifies the original claim is included. Remarks are noted in FL 80 at the bottom of the claim.

1 Your Agency Name Address City ST Zip		3a PAT. CNTL # b. MED REC #		4 TYPE OF CLAIM 327	
5 FED. TAX NO.		6 STATEMENT FROM 10012000		7 COVERS PERIOD THROUGH 11292000	
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000			
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000	
13 HR 1		14 TYPE 1		15 SRC 1	
16 DRG 30		17 STAT D9		18 19 20 21	
22 23 24 25 26 27 28 29		30 31		32	
33 OCCURRENCE DATE CODE		34 OCCURRENCE DATE CODE		35 OCCURRENCE DATE CODE	
36 OCCURRENCE DATE CODE		37 OCCURRENCE DATE CODE		38 OCCURRENCE DATE CODE	
39 OCCURRENCE DATE CODE		40 OCCURRENCE DATE CODE		41 OCCURRENCE DATE CODE	
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE	
45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES	
48 NON-COVERED CHARGES		49			
50 PAYOR A Medicare		51 HEALTH PLAN ID 167999		52 REL INFO Y	
53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE	
56 NPI		57 OTHER PRV ID		58	
59 PREL		60 INSURED'S UNIQUE ID 123456789A		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES A 200010012000093001		64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME		66		67	
68		69 ADMIT DK		70 PATIENT REASON DK	
71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 ATTENDING NPI A12345	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
80 REMARKS Adjusted line item date of service on last therapy visit - from 11/24 to 11/25/2000, and changed 15-minute increments from 3 to 4.		81 CC a		82	
83		84		85	
86		87		88	
89		90		91	
92		93		94	
95		96		97	
98		99		100	

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Chapter 12, Addendum P

FIGURE 12.P-11 CLAIM - CANCELLATION

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