

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH
AGENCY PROSPECTIVE PAYMENT SYSTEM (HHA PPS)

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

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

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

1 Your Agency Name		2		3a PAT. CNTL #		4 TYPE OF BILL	
Address				b. MED REC #		322	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM	
						7 COVERS PERIOD THROUGH	
						10012000 10012000	
8 PATIENT NAME a Doe Jane M			9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000				
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
03151920		F		10012000		1	
14 TYPE		15 SRC		16 DRG		17 STAT	
						30	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37			
38		41 CODE		42 CODE		43 CODE	
		61		1900 00			
44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES	
1 0023 HH Services		10012000				0 00	
2 0001						0 00	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
PAGE OF		CREATION DATE		TOTALS			
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
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 DX		67		68			
A 1629							
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
A12345							
LAST Green		FIRST Mark		LAST		FIRST	
80 REMARKS		b1CC a		b		c	
		b		c		d	

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 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-3 RAP - TRANSFER SITUATION

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

1 Your Agency Name	2		3a PAT. CNTL #			4 TYPE OF BILL															
Address				b. MED REC. #			322														
City		ST	Zip		5 FED. TAX NO			6 STATEMENT FROM		7 COVERS PERIOD THROUGH											
							10162000		10162000												
8 PATIENT NAME			a	Doe Jane M		9 PATIENT ADDRESS			a	123 Main Street Anywhere ST 50000											
b																					
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR		14 TYPE		15 SRC											
03151920		F		10162000		B		30													
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE											
38		41 CODE		VALUE CODES AMOUNT		42 CODE		VALUE CODES AMOUNT		43 CODE		VALUE CODES AMOUNT									
		a		61 1900 00		b		c		d											
		c				d															
		d																			
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES		48 NON-COVERED CHANGES		49							
1 0023		HH Services		HAEJ1		10162000				0 00				1							
2 0001										0 00				2							
3														3							
4														4							
5														5							
6														6							
7														7							
8														8							
9														9							
10														10							
11														11							
12														12							
13														13							
14														14							
15														15							
16														16							
17														17							
18														18							
19														19							
20														20							
21														21							
22														22							
23		PAGE OF		CREATION DATE		TOTALS								23							
50 PAYER		51 HEALTH PL/AN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		A							
A Medicare		167999		Y										A							
B														B							
C														C							
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.						A							
A Doe, Jane M				123456789A										A							
B														B							
C														C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME										A							
A 200010162000101401														A							
B														B							
C														C							
66 1629		67		A		B		C		D		E		F		G		H		68	
I		J		K		L		M		N		O		P		Q					
69 ADMIT DX		70 PATIENT REASON DX		a		b		c		71 PPS CODE		72 ECI		a		b		c		73	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		A12345		QUAL									
								LAST Green				FIRST Mark									
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		76		77 OPERATING NPI				QUAL									
								LAST				FIRST									
80 REMARKS		81 CC a						78 OTHER NPI				QUAL									
		b						LAST				FIRST									
		c						79 OTHER NPI				QUAL									
		d						LAST				FIRST									
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 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-4 RAP - DISCHARGE/RE-ADMIT

Note: 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		2		3a PAT. CNTL.#		4 TYPE OF BILL	
Address				b. MED REC.#		3X2	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM	
						COVERS PERIOD THROUGH	
8 PATIENT NAME		a Doe Jane M		9 PATIENT ADDRESS		a 123 Main Street Anywhere ST 50000	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC 16 DRG 17 STAT	
03151920		F		10162000		C 30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
a		b		c		d	
b		c		d		e	
38		41 CODE		42 VALUE CODES AMOUNT		43 CODE	
		a 61		1900 00		44 VALUE CODES AMOUNT	
		b				45 VALUE CODES AMOUNT	
		c				46 VALUE CODES AMOUNT	
		d				47 VALUE CODES AMOUNT	
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 0023		HH Services		HAEJ1		10162000	
2 0001						0 00	
3						0 00	
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
B						57 OTHER PRV ID	
C							
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				123456789A			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 200010162000101401							
B							
C							
66 1629 67		A		B		C	
DX		I		J		K	
		L		M		N	
		O		P		Q	
		R		S		T	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
		a		b		c	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
		DATE		DATE		DATE	
						76 ATTENDING NPI A12345	
						QUAL	
						LAST Green	
						FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
		DATE		DATE		DATE	
						QUAL	
						LAST	
						FIRST	
80 REMARKS		81 CC a				78 OTHER NPI	
		b				QUAL	
		c				LAST	
		d				FIRST	
						79 OTHER NPI	
						QUAL	
						LAST	
						FIRST	

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-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 RHI's Internal Control Number (ICN) that identified the original RAP is included.

1 Your Agency Name	2	3a PAT. CNTL #	4 TYPE OF BILL
Address		b. MED REC. #	328
City	ST	Zip	
5 FED. TAX NO	6 STATEMENT FROM	COVERS PERIOD THROUGH	7
	10012000	10012000	
8 PATIENT NAME	a Doe Jane M	9 PATIENT ADDRESS	a 123 Main Street Anywhere ST 50000
b		c	d
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC 16 DRG 17 STAT
03151920	F	10012000	30 D5
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE
a			
b			2001952340508
38	41 CODE	VALUE CODES AMOUNT	42 CODE
a	61	1900 00	43 CODE
b			44 CODE
c			45 CODE
d			46 CODE
42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
1 0023	HH Services	HAEJ1	10012000
2 0001			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23	PAGE OF	CREATION DATE	TOTALS
50 PAYER	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN
A Medicare	167999	Y	
B			
C			
58 INSURED'S NAME	59 PREL	60 INSURED'S UNIQUE ID	61 GROUP NAME
A Doe, Jane M		123456789A	
B			
C			
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A 200010012000093001			
B			
C			
66 1629	67	A	B
68	C	D	E
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
74 PRINCIPAL PROCEDURE CODE	a OTHER PROCEDURE CODE	b OTHER PROCEDURE CODE	75
c OTHER PROCEDURE CODE	d OTHER PROCEDURE CODE	e OTHER PROCEDURE CODE	76 ATTENDING NPI
			A12345
80 REMARKS	81 CC	78 OTHER NPI	QUAL
	a		
	b		
	c		
	d		

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CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-6 CLAIM - NON-TRANSFER SITUATION

1 Your Agency Name		2		3a PAT. CNTL. #		4 TYPE OF BILL	
Address				b. MED REC. #		329	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM COVERS PERIOD THROUGH	
						10012000 11292000	
8 PATIENT NAME a Doe Jane M			9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000				
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC 16 DRG 17 STAT	
03151920		F		10012000		30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT		43 VALUE CODES AMOUNT		44	
61 1900 00							
45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES		48 NON-COVERED CHANGES	
0023 HH Services		HAEJ1		10012000		0 00	
0550 Skilled Nurse Visit		G0154		10012000		150 00	
0570 HH Aide		G0156		10012000		75 00	
0550 Skilled Nurse Visit		G0154		10102000		150 00	
0570 HH Aide		G0156		10102000		75 00	
0420 Physical Therapy		G0151		10152000		200 00	
0550 Skilled Nurse Visit		G0154		10202000		150 00	
0570 HH Aide		G0156		10202000		75 00	
0420 Physical Therapy		G0151		10252000		200 00	
0550 Skilled Nurse Visit		G0154		10302000		150 00	
0570 HH Aide		G0156		10302000		75 00	
0420 Physical Therapy		G0151		11042000		200 00	
0550 Skilled Nurse Visit		G0154		11102000		150 00	
0570 HH Aide		G0156		11102000		75 00	
0420 Physical Therapy		G0151		11142000		200 00	
0550 Skilled Nurse Visit		G0154		11202000		150 00	
0570 HH Aide		G0156		11202000		75 00	
0420 Physical Therapy		G0151		11242000		200 00	
0550 Skilled Nurse Visit		G0154		11292000		150 00	
0570 HH Aide		G0156		11292000		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	
A Medicare		167999		Y			
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
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 67		A B C D E F G H		I J K L M N O P Q		68	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
A12345							
LAST Green		FIRST Mark		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
		81 CC b		c		d	

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 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-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				2				3a PAT. CNTRL #				4 TYPE OF BILL																															
Address								b. MED REC. #				329																															
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		ADMISSION 13 HR		14 TYPE		15 SRC		16 DRG		17 STAT		18		19		20		21		CONDITION CODES		22		23		24		25		26		27		28		29 ACDT		30 STATE	
03151920		F		10012000		B		30																																			
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38		39		40		41		42		43		44		45		46		47		48		49							
a		b		c		d		e		f		g		h		i		j		k		l		m		n		o		p		q		r									
b		c		d		e		f		g		h		i		j		k		l		m		n		o		p		q		r		s									
38				41 CODE				42 CODE				43 CODE				44 CODE				45 CODE																							
				a 61				b				c				d				e																							
				1900				00																																			
				a				b				c				d				e																							
42 REV CD.		43 DESCRIPTION				44 HCPCS / RATE / HIPPS CODE				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES		48 NON-COVERED CHANGES		49																									
1	0023	HH Services				HAEJ1				10012000				0		00																											
2	0550	Skilled Nurse Visit				G0154				10012000		2		150		00																											
3	0570	HH Aide				G0156				10012000		3		75		00																											
4	0550	Skilled Nurse Visit				G0154				10102000		2		150		00																											
5	0570	HH Aide				G0156				10102000		2		75		00																											
6	0420	Physical Therapy				G0151				10152000		3		200		00																											
7	0550	Skilled Nurse Visit				G0154				10202000		2		150		00																											
8	0570	HH Aide				G0156				10202000		2		75		00																											
9	0420	Physical Therapy				G0151				10252000		3		200		00																											
10	0550	Skilled Nurse Visit				G0154				10302000		2		150		00																											
11	0570	HH Aide				G0156				10302000		2		75		00																											
12	0420	Physical Therapy				G0151				11042000		3		200		00																											
13	0550	Skilled Nurse Visit				G0154				11102000		1		150		00																											
14	0570	HH Aide				G0156				11102000		2		75		00																											
15	0420	Physical Therapy				G0151				11142000		3		200		00																											
16	0550	Skilled Nurse Visit				G0154				11202000		2		150		00																											
17	0570	HH Aide				G0156				11202000		3		75		00																											
18	0420	Physical Therapy				G0151				11242000		3		200		00																											
19	0550	Skilled Nurse Visit				G0154				11292000		2		150		00																											
20	0570	HH Aide				G0156				11292000		2		75		00																											
21	0270	Supplies										11		132		58																											
22	0001											43		2707		58																											
23		PAGE ____ OF ____				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																									
A Medicare				167999				Y										57																									
B																		OTHER PRV ID																									
C																																											
58 INSURED'S NAME				59 PREL		60 INSURED'S UNIQUE ID				61 GROUP NAME				62 INSURANCE GROUP NO.																													
A Doe, Jane M						123456789A																																					
B																																											
C																																											
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME																																			
A 200010012000093001																																											
B																																											
C																																											
66 1629		67		A		B		C		D		E		F		G		H		68																							
I		J		K		L		M		N		O		P		Q																											
69 ADMIT DX		70 PATIENT REASON DX		a		b		c		71 PPS CODE		72 ECI		a		b		c		73																							
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		c. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		A12345		QUAL				LAST		FIRST																							
										LAST		Green						FIRST		Mark																							
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		76		77 OPERATING NPI		QUAL				LAST		FIRST		78 OTHER NPI		QUAL																							
										LAST				LAST		FIRST		79 OTHER NPI		QUAL																							
										LAST				LAST		FIRST		LAST		FIRST																							
										LAST				LAST		FIRST		LAST		FIRST																							

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CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-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 PAT. CNTL.#		4 TYPE OF BILL	
Address				b. MED REC.#		329	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM COVERS PERIOD THROUGH	
				10012000		11292000	
8 PATIENT NAME a Doe Jane M				9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR	
03151920		F		10012000		1	
14 TYPE		15 SRC		16 DRG		17 STAT	
						30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37			
38		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT		43 VALUE CODES AMOUNT	
		61 1900 00					
44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES	
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		3		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 Medicare		51 HEALTH PL/AN ID 167999		52 REL INFO Y		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Doe, Jane M		59 PREL 60 INSURED'S UNIQUE ID 123456789A		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES 200010012000093001		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 1629 67 A B C D E F G H		68		69 ADMIT DX		70 PATIENT REASON DX	
71 PPS CODE		72 ECI		73			
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
						76 ATTENDING NPI A12345	
						LAST Green FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
						LAST FIRST	
80 REMARKS		81 CC a		b		78 OTHER NPI	
		c		d		LAST FIRST	
						79 OTHER NPI	
						LAST FIRST	

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-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			2		3a PAT. CNTRL #		4 TYPE OF BILL																
Address				b. MED REC. #		329																	
City			ST	Zip		5 FED. TAX NO		6 STATEMENT FROM		7 COVERS PERIOD THROUGH													
					10012000		10032000																
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		ADMISSION 13 HR 14 TYPE 15 SRC		16 DRG	17 STAT				CONDITON CODES		18 19 20 21		22 23 24		25 26 27 28		29 ACDT STATE		30	
03151920		F	10012000		1		06																
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37											
38			41 CODE		VALUE CODES AMOUNT		42 CODE		VALUE CODES AMOUNT		41 CODE		VALUE CODES AMOUNT										
			61		1900 00																		
42 REV CD.			43 DESCRIPTION			44 HCPCS / RATE / HIPPS CODE			45 SERV. DATE		46 SERV. UNITS	47 TOTAL CHANGES		48 NON-COVERED CHANGES		49							
1	0023	HH Services			HAEJ1			10012000			0 00												
2	0550	Skilled Nurse Visit			G0154			10012000		2	150 00												
3	0570	HH Aide			G0156			10012000		3	75 00												
4																							
5	0001									5	225 00												
6																							
7																							
8																							
9																							
10																							
11																							
12																							
13																							
14																							
15																							
16																							
17																							
18																							
19																							
20																							
21																							
22																							
23	PAGE			OF			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			B 167999			Y								C		C							
58 INSURED'S NAME			59 PREL			60 INSURED'S UNIQUE ID			61 GROUP NAME			62 INSURANCE GROUP NO.											
A Doe, Jane M						B 123456789A						C											
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME																	
A 200010012000093001												C											
66 1629		67		A		B		C		D		E		F		G		H		I		68	
				J		K		L		M		N		O		P		Q					
69 ADMIT DX		70 PATIENT REASON DX		a		b		c		71 PPS CODE		72 ECI		a		b		c		73			
74 PRINCIPAL PROCEDURE CODE		75		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		A12345		QUAL									
										LAST Green				FIRST Mark									
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE						77 OPERATING NPI				QUAL									
										LAST				FIRST									
80 REMARKS			81 CC								78 OTHER NPI		QUAL										
			a								LAST		FIRST										
			b																				
			c								79 OTHER NPI		QUAL										
			d								LAST		FIRST										

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-10 CLAIM ADJUSTMENT

NOTE: 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		2		3a PAT. CNTL #		4 TYPE OF BILL	
Address				b. MED REC. #		327	
City		ST Zip		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	
b				c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION	
03151920		F		10012000		13 HR 14 TYPE 15 SRC	
				16 DRG		17 STAT	
				30		18 19 20 21	
				D9		22 23 24 25 26 27 28	
						29 ACDT 39 STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
						35 OCCURRENCE SPAN FROM THROUGH	
						36 OCCURRENCE SPAN FROM THROUGH	
						37	
						2002332340508	
38				41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
				a 61 1900 00			
				b			
				c			
				d			
42 REV CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 0023		HH Services		HAEJ1		10012000	
2 0550		Skilled Nurse Visit		G0154		10012000	
3 0570		HH Aide		G0156		10012000	
4 0550		Skilled Nurse Visit		G0154		10102000	
5 0570		HH Aide		G0156		10102000	
6 0420		Physical Therapy		G0151		10152000	
7 0550		Skilled Nurse Visit		G0154		10202000	
8 0570		HH Aide		G0156		10202000	
9 0420		Physical Therapy		G0151		10252000	
10 0550		Skilled Nurse Visit		G0154		10302000	
11 0570		HH Aide		G0156		10302000	
12 0420		Physical Therapy		G0151		11042000	
13 0550		Skilled Nurse Visit		G0154		11102000	
14 0570		HH Aide		G0156		11102000	
15 0420		Physical Therapy		G0151		11142000	
16 0550		Skilled Nurse Visit		G0154		11202000	
17 0570		HH Aide		G0156		11202000	
18 0420		Physical Therapy		G0151		11242000	
19 0550		Skilled Nurse Visit		G0154		11292000	
20 0570		HH Aide		G0156		11292000	
21 0270		Supplies				11 132 58	
22 0001						43 2707 58	
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A Medicare		167999		Y			
B						54 PRIOR PAYMENTS	
C						55 EST. AMOUNT DUE	
						56 NPI	
						57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A Doe, Jane M				123456789A			
B							
C						62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 200010012000093001							
B							
C							
66 DX		67		A B C D E F G H		68	
				I J K L M N O P Q			
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
						76 ATTENDING NPI A12345	
						QUAL	
						LAST Green	
						FIRST Mark	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI	
						QUAL	
						LAST	
						FIRST	
80 REMARKS		81 CCI		78 OTHER NPI		QUAL	
Adjusted line item date of service on last therapy visit - from 11/24		a				LAST	
to 11/25/2000, and changed 15-minute increments from 3 to 4.		b				FIRST	
		c				79 OTHER NPI	
		d				QUAL	
						LAST	
						FIRST	

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 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM R

EXAMPLES OF CLAIMS SUBMISSION UNDER HOME HEALTH AGENCY PROSPECTIVE PAYMENT SYSTEM

FIGURE 12-R-11 CLAIM - CANCELLATION

NOTE: The TOB changes to end in an 8, a Claim Change Reason Code (e.g., D6) is included, and the RHHI's ICN that identified the original claim is included.

1 Your Agency Name		2		3a PAT. CNTRL #		4 TYPE OF BILL			
Address				b. MED REC. #		328			
City		ST Zip		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	
b		c		d		e			
10 BIRTHDATE		11 SEX		12 DATE		13 HR			
03151920		F		10012000		1			
14 TYPE		15 SRC		16 DRG		17 STAT			
						30			
18		19		20		21			
22		23		24		25			
26		27		28		29 ACDT STATE			
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE			
						30			
35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37		2002332340508			
38		41 CODE		42 CODE		43 CODE			
		61		1900 00					
44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHANGES			
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			
23 PAGE OF		CREATION DATE		TOTALS					
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN			
A Medicare		167999		Y					
B						54 PRIOR PAYMENTS			
C						55 EST. AMOUNT DUE			
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME			
A Doe, Jane M				123456789A					
B						62 INSURANCE GROUP NO.			
C									
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME					
A 200010012000093001									
B									
C									
66 1629 67		A		B		C			
D		E		F		G			
H		I		J		K			
L		M		N		O			
P		Q		R		S			
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI			
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75			
						76 ATTENDING NPI A12345			
						QUAL			
						LAST FIRST			
						Green Mark			
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		77 OPERATING NPI			
						QUAL			
						LAST FIRST			
80 REMARKS		81 CC a		b		78 OTHER NPI			
						QUAL			
						LAST FIRST			
						79 OTHER NPI			
						QUAL			
						LAST FIRST			

UB-04 CMS-1450

APPROVED OMB NO.

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