Humana Healthy Horizons in Florida Claim Form Provider Resource Guide

Welcome to Humana Healthy Horizons® in Florida, a Medicaid managed care program focused on helping members achieve their best health.

Providers can submit a clean claim by providing the required data elements on the standard claim forms along with any attachments and additional information. Inpatient and facility claims are to be submitted on the UB-04 form, and individual professional claims are to be submitted on the CMS 1500 form. This provider resource guide lists requirements for the CMS-1500 and the UB-04 forms.

To prevent claim denials or rejections, please be sure to submit claims according to the corresponding Provider Master List (PML) record for the billing and rendering provider (if applicable). If changes need to be made to PML records, please call Provider Enrollment Support at **800-289-7799**, option 4, Monday – Friday, 8 a.m. – 5 p.m., Eastern time, or request changes via the **secured web portal**.

You can find updates to this provider resource guide at the **Humana Healthy Horizons provider site**.

CMS-1500 form requirements

Field number	Title	Description
1	Medicare, Medicaid, TRICARE™, CHAMPVA, group health plan, FECA*, black lung, other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only 1 box can be marked.
1a	Insured's ID number	Enter the insured's Humana member ID (begins with an "H") as shown on the insured's ID card for the payer to which the claim is being submitted. For Medicare crossover claims, enter the Medicare ID number in this field.
2	Patient's name	Enter the patient's full last name, first name and middle initial as it appears on the Medicaid ID card or other proof of eligibility (required).
3	Patient's birth date, sex	Enter the patient's 8-digit birth date (MM|DD|YYYY). Enter an X in the correct box to indicate gender of the patient.

Humana
Healthy Horizons®
in Florida

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.
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Field number	Title	Description
4	Insured's name	Enter the insured's full last name, first name and middle initial. No entry required unless the recipient is covered by other insurance.
5	Patient's address (multiple fields)	Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. No entry is required, but the information may be helpful to identify a recipient if the Medicaid ID is incorrect.
6	Patient relationship to insured	Enter an X in the correct box to indicate the patient's relationship to the insured when Field No. 4 is completed. No entry required.
7	Insured's address (multiple fields)	Enter the insured's address. If Field No. 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. No entry required unless the recipient is covered by other insurance.
8	Reserved for NUCC† use	This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.
9	Other insured's name	If Field No. 11d is marked, complete Field Nos. 9, 9a and 9d; otherwise, leave blank. When additional group health coverage exists, enter other insured's full last name, first name and middle initial of the member in another health plan if it is different from that shown in Field No. 2.
9a	Other insured's policy or group number	Enter the policy or group number of the other insured.
9b	Reserved for NUCC use	This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.
9c	Reserved for NUCC use	This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.
10a	Is patient's condition related to:	When appropriate, enter an X in the correct box to indicate whether 1 or more of the services described in Field No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only 1 box on each line can be marked. Enter an X in any parts that apply and give corresponding information in Field Nos. 10a–c.

Field number	Title	Description
10b	Is patient's condition related to:	When appropriate, enter an X in the correct box to indicate whether 1 or more of the services described in Field No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only 1 box on each line can be marked. Enter an X in any parts that apply and give corresponding information in Field Nos. 10a-c.
10c	Is patient's condition related to:	When appropriate, enter an X in the correct box to indicate whether 1 or more of the services described in Field No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only 1 box on each line can be marked. Enter an X in any parts that apply and give corresponding information in Field Nos. 10a–c.
10d	Claim codes	When required by payers to provide the subset of Condition Codes approved by the NUCC, enter the Condition Code in this field. No entry is required for Medicaid-only billing. For Medicare crossover claims, enter the recipient's 10-digit Medicaid ID.
11	Insured's policy, group, or FECA number	Enter the insured's policy or group number as it appears on the insured's healthcare ID card. If Field No. 4 is completed, then this field should be completed.
11a	Insured's date of birth, sex	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. No entry required.
11b	Other claim ID (designated by NUCC)	Enter the "Other Claim ID." No entry required.
11c	Insurance plan name or program name	Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field. No entry required.
11d	Is there another health benefit plan?	When appropriate, enter an X in the correct box. If marked "YES," complete Field Nos. 9, 9a and 9d. Only 1 box can be marked. No entry required.
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF" or a legal signature. For a legal signature, enter the date signed in 6-digit (MM|DD|YY) or 8 digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File." No entry required.
13	Insured's or authorized person's signature	Enter "Signature on File," "SOF" or a legal signature. If there is no signature on file, leave blank or enter "No Signature on File." No entry required.

Field number	Title	Description
14	Date of current illness, injury, or pregnancy (last menstrual period [LMP])	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury or pregnancy. No entry required.
15	Other date	Enter the applicable qualifier to identify which date is being reported: • 454 Initial Treatment • 304 Latest Visit or Consultation • 453 Acute Manifestation of a Chronic Condition • 439 Accident • 455 Last X-ray • 471 Prescription • 090 Report Start (Assumed Care Date) • 091 Report End (Relinquished Care Date) • 444 First Visit or Consultation Enter another date related to the patient's condition or treatment. Enter QUAL (qualifier) first, then the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. No entry required.
16	Dates patient unable to work in current occupation	If the patient is employed and unable to work in current occupation, a 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date must be shown for the "from – to" dates that the patient is unable to work. No entry required.
17	Name of referring provider or other source	Enter the name (first name, middle initial, last name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass primary care provider (PCP) or did not require service authorization.
17a	Other ID number	The other ID number of the referring, ordering or supervising provider is reported in Field No. 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of Field No. 17a.

Field number	Title	Description
17b	National Provider Identifier (NPI) number	Enter the NPI number of the referring, ordering or supervising provider in Field No. 17b. Enter either qualifier code 1D and the Medicaid provider number in Field No. 17a or the NPI number in Field No. 17b. If you enter the NPI in 17band the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, in Field No. 17a, enter qualifier code ZZ in the small field and enter the referring provider's taxonomy in the large field of Field No. 17a.
18	Hospitalization dates related to current services	Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave the discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization. No entry is required, but an entry is preferred.
19	Additional claim information (designated by NUCC)	Please refer to the most current instructions from the public or private payer regarding the use of this field. No entry required.
20	Outside lab? $ charges	Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's antimarkup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. No entry required.
21	Diagnosis or nature of illness or injury	Enter the applicable International Classification of Diseases (ICD) indicator to identify which version of ICD codes is being reported.
22	Resubmission code and/or original reference number	List the original reference number for resubmitted claims. No entry required.
23	Prior authorization number	Enter any of the following: prior authorization number, referral number, mammography precertification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.
24a	Date(s) of service [lines 1–6]	Enter date(s) of service, both the "From" and "To" dates.
24b	Place of service [lines 1–6]	In Field No. 24b, enter the appropriate 2-digit code from the Place of Service Code list for each item used or service performed.

Field number	Title	Description
24c	EMG [lines 1–6]	Check with payer to determine if this information (emergency indicator) is necessary. If the service was an emergency, enter a "Y" for yes in the unshaded area of the field. If the service was not an emergency, leave the field blank.
24d	Procedures, services, or supplies [lines 1–6]	Enter the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service.
24e	Diagnosis pointer [lines 1–6]	In Field No. 24e, enter the diagnosis code reference letter (pointer) as shown in Field No. 21 to relate the date of service and the procedures performed to the primary diagnosis.
24f	$ Charges [lines 1–6]	Enter the charge amount for each listed service.
24g	Days or units [lines 1–6]	Enter the number of days or units.
24h	EPSDT/Family plan [lines 1–6]	For reporting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and family planning services, refer to specific payer instructions. Hospice: For all recipients in hospice, enter H in the shaded area of Field No. 24h.
24i	ID qualifier [lines 1-6]	Enter in the shaded area of 24i the qualifier identifying the number is a non-NPI. The other ID number of the rendering provider should be reported in 24j in the shaded area. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 claim form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification or area of specialization. Both provider identifiers and provider taxonomy may be used in this field.

Field number	Title	Description
24i	ID qualifier [lines 1-6] (continued)	The rendering provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the identification number in Field Nos. 24i and 24j only when different from data recorded in Field Nos. 33a and 33b. Description: If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24j	Rendering provider ID number [lines 1–6]	The individual rendering the service is reported in 24j. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The rendering provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the identification number in Field Nos. 24i and 24j only when different from data recorded in Field Nos. 33a and 33b. Enter numbers left justified in the field. Description: The individual performing/rendering the service should be reported in 24j, and the qualifier indicating if the number is a non-NPI is reported in 24i. The non-NPI ID number of the rendering provider refers to the payer-assigned unique identifier of the professional. Field specification: This field allows for the entry of 11 characters in the shaded area and entry of a 10-digit NPI number of the unshaded area.
25	Federal Tax ID number	Enter the "Federal Tax ID number" (employer ID number or Social Security number) of the billing provider identified in Field no. 33. No entry required.
26	Patient's account no.	Enter the patient's account number assigned by the provider of the service's or supplier's accounting system. The provider may enter a recipient account number so that it will appear on the remittance advice.
27	Accept assignment?	Enter an X in the correct box. Only 1 box can be marked. No entry required.

Field number	Title	Description
28	Total charge	Enter total charges for the services (i.e., total of all charges in Field No. 24f).
29	Amount paid	Enter the total amount the patient and/or other payers paid on the covered services only.
30	Reserved for NUCC use	This field was previously used to report "balance due." "Balance due" does not exist in 5010A1, so this field has been eliminated. No entry required.
31	Signature of Provider or supplier including degrees or credentials	"Signature of provider or supplier including degrees or credential" does not exist in 5010A1, so this field has been eliminated.
32	Service facility location information	Enter the name, address, city, state and ZIP code of the location where the services were rendered.
32a	NPI	Enter the NPI number of the service facility location in 32a. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.
32b	Other ID number	Enter the qualifier identifying the non-NPI number followed by the ID number. No entry required.
33	Billing provider info & phone #	Enter the provider's or supplier's billing name, address, ZIP code and phone number.
33a	NPI number	Enter the NPI number of the billing provider
33b	Other ID number	Enter the qualifier identifying the non-NPI number followed by the ID number.

UB-04 form requirements

Field locator	Title	Action
1	Provider name, address, telephone number, fax number and country code (if other than U.S.)	Line 1: Provider name Line 2: Street address or P.O. Box Line 3: City, state and ZIP code plus 4 Line 4: Telephone, fax; country code (if other than U.S.)
2	Pay-to name, address and NPI number	Report only when pay-to name and address are different than the billing provider in Form Locator 1.
3a	Patient control number	Enter the patient's unique (alphanumeric) number assigned by the provider. Any letter or number combination up to 20 digits is acceptable.
3b	Medical record number	Enter the number assigned to the patient's medical or health record by the provider. This is an optional field.

Field locator	Title	Action
4	Type of bill	Enter the appropriate 4-digit code for the type of bill from the coding table below. **Inpatient type of bill codes:** • 0110 Inpatient Non-Payment (Zero Claim) • 0111 Inpatient Admit through Discharge Date • 0112 Interim (First Claim) • 0113 Interim (Continuing Claim) • 0114 Interim (Last Claim) • 0117 Inpatient Replacement of Prior Claim (Adjustment) • 0118 Inpatient Void (Cancel of Prior Claim) • 0121 Inpatient Medicare B Only **Outpatient type of bill codes:** • 0130 Outpatient Non-Payment (Zero Claim) • 0131 Outpatient Claim • 0137 Outpatient Replacement of Prior Claim (Adjustment) • 0138 Outpatient Void (Cancel of Prior Claim) • 0141 Outpatient Non-Patient Diagnostic Laboratory Claim **Critical access hospitals:** • 0851 Special Facility—Critical Access Hospital Original Claims • 0857 Special Facility—Critical Access Hospital Replacement of Prior Claim (Adjustment) • 0858 Critical Access Hospital Voids **Freestanding dialysis center type of bill codes:** • 0721 Freestanding Dialysis Center Original Claims • 0727 Freestanding Dialysis Center Replacement of Prior Claim (Adjustment) • 0728 Freestanding Dialysis Center Voids **Hospice type of bill codes:** • 0813 Hospice Original Claims • 0817 Hospice Replacement of Prior Claim (Adjustment) • 0818 Hospice Voids **Long-term care (skilled nursing and ICF/DDs) type of bill codes:** • 0251 Skilled Nursing Facility (SNF) Level I Original Claims • 0257 Skilled Nursing Facility (SNF) Level I Replacement of Prior Claim (Adjustment) • 0258 Skilled Nursing Facility (SNF) Level I Voids

Field locator	Title	Action
4	Type of bill (continued)	• 0261 Skilled Nursing Facility (SNF) Level II Original Claims • 0267 Skilled Nursing Facility (SNF) Level II Replacement of Prior Claim (Adjustment) • 0268 Skilled Nursing Facility (SNF) Level II Voids • 0651 Intermediate Care Facility (ICF) Level I Original Claims • 0657 Intermediate Care Facility (ICF) Level I Replacement of Prior Claim (Adjustment) • 0658 Intermediate Care Facility (ICF) Level I Voids • 0661 Intermediate Care Facility (ICF) Level II Original Claims • 0667 Intermediate Care Facility (ICF) Level II Replacement of Prior Claim (Adjustment) • 0668 Intermediate Care Facility (ICF) Level II Voids
5	Federal tax number	Enter federal tax number as NN-NNNNNNN.
6	Statement covers period—from/through	Inpatient: Enter the beginning and ending service dates for this bill in month, day, year format (MMDDYY). For admission and discharge on the same day, the "from" and "through" dates are the same. Inpatient psychiatric services: Enter the beginning and ending service dates of the period included by this bill in MMDDYY format (Example: 042107 for April 21, 2007). Outpatient: Enter the date of service in MMDDYY format. Only the services received in a single day can be billed on an outpatient claim, with the exception of outpatient Medicare crossover claims. The "from" and "through" dates are the same. Freestanding dialysis center: Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient's Medicaid eligibility began. For services received on a single day, the "from" and "through" dates must be the same. Hospice: Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient's Medicaid eligibility began. For services received on a single day, the "from" and "through" dates must be the same. Long-term care facilities (skilled nursing facilities and intermediate care facilities for the developmentally disabled [ICFs/DDs]): Enter the beginning and ending service dates for the month being billed in MMDDYY format.
7	Unlabeled	No entry required.

<table>
<tr><th>Field locator</th><th>Title</th><th>Action</th></tr>
<tr><td>8a</td><td>Patient ID</td><td>Report only if number is different from the insured's ID in Form Locator 60.</td></tr>
<tr><td>8b</td><td>Patient name</td><td>Enter the recipient's last name, first name and middle initial exactly as it appears on the Medicaid ID card or other Medicaid proof of eligibility.</td></tr>
<tr><td>9</td><td>Patient address</td><td>Subfield a: Street address or P.O. Box
Subfield b: City
Subfield c: State
Subfield d: ZIP code
Subfield e: Country code (no entry required)</td></tr>
<tr><td>10</td><td>Patient birthdate</td><td>Enter the patient's date of birth in the MMDDYYYY format.</td></tr>
<tr><td>11</td><td>Patient sex</td><td>Enter the letter "M" if the patient is male, "F" if the patient is female or "U" if unknown.</td></tr>
<tr><td>12</td><td>Admission date</td><td>Inpatient: Enter the patient's date of admission in the MMDDYY format. Example: 042107 for April 21, 2007.
Outpatient: Enter the date of service.
Freestanding dialysis centers: No entry required.
Hospice: Enter the patient's date of admission in MMDDYY format. This date must be the same as the effective date of hospice election or change of election.
Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the patient's date of admission to the facility or to a new level of care in MMDDYY format.</td></tr>
<tr><td>13</td><td>Admission hour</td><td>Inpatient: No entry required but desirable. Enter the code for the hour of admission converted to 24-hour time as shown below:
<table>
<tr><th>Code</th><th>Time a.m.</th><th>Code</th><th>Time p.m.</th></tr>
<tr><td>00</td><td>12:00–12:59 (midnight)</td><td>12</td><td>12:00-12:59 (noon)</td></tr>
<tr><td>01</td><td>01:00–01:59</td><td>13</td><td>01:00–01:59</td></tr>
<tr><td>02</td><td>02:00–02:59</td><td>14</td><td>02:00–02:59</td></tr>
<tr><td>03</td><td>03:00–03:59</td><td>15</td><td>03:00–03:59</td></tr>
<tr><td>04</td><td>04:00–04:59</td><td>16</td><td>04:00–04:59</td></tr>
<tr><td>05</td><td>05:00–05:59</td><td>17</td><td>05:00–05:59</td></tr>
<tr><td>06</td><td>06:00–06:59</td><td>18</td><td>06:00–06:59</td></tr>
<tr><td>07</td><td>07:00–07:59</td><td>19</td><td>07:00–07:59</td></tr>
<tr><td>08</td><td>08:00–08:59</td><td>20</td><td>08:00–08:59</td></tr>
<tr><td>09</td><td>09:00–09:59</td><td>21</td><td>09:00–09:59</td></tr>
<tr><td>10</td><td>10:00–10:59</td><td>22</td><td>10:00–10;59</td></tr>
<tr><td>11</td><td>11:00–11:59</td><td>23</td><td>11:00–11:59</td></tr>
</table></td></tr>
</table>

Field locator	Title	Action
13	Admission hour (continued)	Outpatient: No entry required but desirable. Hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required.
14	Type of admission or visit	Inpatient: Enter the code indicating the priority of this admission: **1.** Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room (ER). **2.** Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. **3.** Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation. **4.** Newborn: This is a baby born within this facility. Use of this code necessitates the use of special source of admission codes. See Form Locator 15. **5.** Trauma center: This is a visit to a trauma center or hospital as licensed or designated by the state or local government authority authorized to do so or as verified by the American College of Surgeons and involves a trauma activation. **9.** Information is not available. Outpatient: Enter code 1 for emergencies, code 2 for urgent cases, or code 5 (trauma center) if the patient was seen in a trauma center or hospital. Otherwise, no entry is required. MediPass authorization is not required if the type of admission is 1 or 5. Hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required.
15	Source of referral for admission or visit	Inpatient, hospice and freestanding dialysis centers: Enter the code indicating the source of the referral for this admission or visit. Newborn coding must be used when the type of admission code in Form Locator 14 is 4. See below for newborn codes. Admission source codes: (excluding newborn) 1 – Provider referral: The patient was admitted to this facility upon the recommendation of his/her personal provider.

Field locator	Title	Action
15	Source of referral for admission or visit (continued)	2 – Clinic referral: The patient was admitted to this facility upon recommendation of this facility's clinic provider. 3 – Health maintenance organization (HMO) referral: The patient was admitted to this facility upon the recommendation of an HMO provider. 4 – Transfer from a hospital: The patient was admitted to this facility as a transfer from an acute care facility where he/she was an inpatient. 5 – Transfer from a skilled nursing facility: The patient was admitted to this facility as a transfer from a skilled nursing facility where he/she was a resident. 6 – Transfer from another healthcare facility: The patient was admitted to this facility as a transfer from a healthcare facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes and long-term care facilities and skilled nursing patients who are at a non-skilled level of care. 7 – Emergency room: The patient was admitted to this facility upon the recommendation of this facility's ER provider. 8 – Court or law enforcement: The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative. 9 – Information not available: The means by which the patient was admitted to this facility is not known. A – Transfer from a critical access hospital: The patient was admitted to this facility as a transfer from a critical access hospital where he/she was an inpatient. **Source codes for newborns:** 1 - Normal delivery: A baby delivered without complications 2 - Premature delivery: A baby delivered with time or weight factors qualifying the baby for premature status 3 - Sick baby: A baby delivered with medical complications other than those relating to premature status 4 - Extramural birth: A newborn born in a nonsterile environment

Field locator	Title	Action
16	Discharge hour	Inpatient: Enter the hour of discharge from the hospital converted to 24-hour time as shown in the coding table for Form Locator 13. Outpatient: No entry required but desirable. Freestanding dialysis centers: No entry required. Hospice: No entry required. Long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required.
17	Patient discharge status	Inpatient, outpatient and hospice: Enter the code indicating patient status as of the discharge date or last date billed in the case of interim billing as reported in Form Locator 6—Statement covers period.
18	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
19	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
20	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
21	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.

Field locator	Title	Action
22	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
23	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
24	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
25	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
26	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
27	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.

Field locator	Title	Action
28	Condition codes	Inpatient, outpatient, freestanding dialysis centers, hospice and long-term care facilities (skilled nursing facilities and ICFs/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the condition code fields are filled, use the Form Locator 81 Code-code field with qualifier code A1.
29	Accident state	When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred, e.g., FL, GA, etc.
30	Unlabeled	No entry required.
31	Occurrence code and date	Inpatient and outpatient: Enter the code and associated date defining a significant event relating to this bill. If only 1 code and date are used, they must be entered in Form Locator 31a. If more than 1 code and date are used, they must be entered in Form Locators 31a –34a, then 31b–34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the occurrence code fields are filled, use available occurrence span code fields (35–36).
32	Occurrence code and date	Inpatient and outpatient: Enter the code and associated date defining a significant event relating to this bill. If only 1 code and date are used, they must be entered in Form Locator 31a. If more than 1 code and date are used, they must be entered in Form Locators 31a–34a, then 31b–34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the occurrence code fields are filled, use available occurrence span code fields (35–36).
33	Occurrence code and date	Inpatient and outpatient: Enter the code and associated date defining a significant event relating to this bill. If only 1 code and date are used, they must be entered in Form Locator 31a. If more than 1 code and date are used, they must be entered in Form Locators 31a–34a, then 31b–34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the occurrence code fields are filled, use available occurrence span code fields (35–36).

Field locator	Title	Action
34	Occurrence code and date	Inpatient and outpatient: Enter the code and associated date defining a significant event relating to this bill. If only 1 code and date are used, they must be entered in Form Locator 31a. If more than 1 code and date are used, they must be entered in Form Locators 31a–34a, then 31b–34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the occurrence code fields are filled, use available occurrence span code fields (35–36).
35	Occurrence span code and dates	If condition code C3 was entered in Form Locators 18–28, enter occurrence code M0 and the first and last days that were approved when not all of the stay was approved.
35a	Occurrence span code and dates	If condition code C3 was entered in Form Locators 18–28, enter occurrence code M0 and the first and last days that were approved when not all of the stay was approved.
36	Occurrence span code and dates	If condition code C3 was entered in Form Locators 18–28, enter occurrence code M0 and the first and last days that were approved when not all of the stay was approved.
37	Unlabeled	No entry required.
38	Responsible party name and address	No entry required.
39a–d	Value codes and amounts	Inpatient and outpatient: This is required for Medicare and Medicaid crossovers only if 1 or more of the codes below are applicable. Hospice: Enter the value code and amount if applicable. 31 Patient responsibility: Enter value code 31 and the amount of patient liability even if the amount is $0. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the value code and amount. 31 Patient responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as 1 day. The Department

Field locator	Title	Action
39a–d	Value codes and amounts (continued)	of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim. For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a qualified Medicare beneficiary (QMB) only or a QMB plus. There is no patient responsibility for QMB and QMB-plus nursing facility residents during the Medicare coinsurance period. Covered days: 80 is the number of days covered by the primary payer as qualified by the payer.
40a–d	Value codes and amounts	Inpatient and outpatient: This is required for Medicare and Medicaid crossovers only if 1 or more of the codes below are applicable. Hospice: Enter the value code and amount if applicable. 31 Patient responsibility: Enter value code 31 and the amount of patient liability, even if $0. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the value code and amount. 31 Patient responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as 1 day. The DCF staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim.

Field locator	Title	Action
40a–d	Value codes and amounts (continued)	For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB plus. There is no patient responsibility for QMB and QMB-plus nursing facility residents during the Medicare coinsurance period. Covered days: 80 is the number of days covered by the primary payer as qualified by the payer.
41a–d	Value codes and amounts	Hospice: Enter the value code and amount if applicable. 31 Patient responsibility: Enter value code 31 and the amount of patient liability, even if $0. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the value code and amount. 31 Patient responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as 1 day. The DCF staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim. For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB plus. There is no patient responsibility for QMB and QMB-plus nursing facility residents during the Medicare coinsurance period. Covered days: 80 is the number of days covered by the primary payer as qualified by the payer.

Field locator	Title	Action
42	Revenue code	Enter the appropriate 4-digit revenue codes itemizing accommodations, services and items furnished to the patient in your facility. Freestanding dialysis centers: Revenue center codes 0821 and 0831 represent covered services. Revenue codes 0821 and 0831 may be billed only once on the claim. Enter the number of units in Form Locator 46. Chapter 3 of the Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations Handbook lists the drugs that are billed with revenue center codes 0634, 0635 and 0636. When billing for a drug, enter the corresponding 5-digit HCPCS procedure code in Form Locator 44. Use revenue code 0636 when dispensing Florida Agency for Health Care Administration (AHCA)-specified charges for drugs and biologics that are billed under revenue code 0636 (with the exception of radiopharmaceuticals, which are reported under revenue codes 0343 and 0344) and require specific identification. If using an HCPCS code to describe the drug, enter the corresponding 5-digit HCPCS procedure code in Form Locator 44. Enter the specific service units reported in hundreds (100s), rounded to the nearest hundred; do not use a decimal.
43	Revenue code description	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs: Enter a written description of the related revenue categories included on this bill. Line 23: Page__of__: On multiple page claims, all required fields must be completed on each page of the claim. Enter the page number and the total number of pages on the bottom of each claim page. For example, the first page would be numbered page 1 of 2, the second, page 2 of 2, etc. Outpatient: Florida Medicaid is collecting National Drug Code (NDC) information on Centers for Medicare & Medicaid Services (CMS) designated provider-administered drugs in the outpatient hospital setting. The NDC is required on claims for drugs, including Medicare Medicaid crossover claims for drugs. See the instructions below for entering the NDC. Freestanding dialysis centers: The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims

Field locator	Title	Action
43	Revenue code description (continued)	for drugs. See the instructions below for entering the NDC. Florida Medicaid will reimburse freestanding dialysis centers only for drugs for which the manufacturer has a federal rebate agreement per the Social Security Act, see SEC. 1927 [42 U.S.C. 1396r-8]. The current list of manufacturers who have drug rebate agreements is available on AHCA's website. Select Medicaid and then Go to Medicaid, scroll down and select Pharmacy Policy, then select Preferred Drug Program and then select List of Manufacturers with Federal Rebates. Instructions for entering the NDC: When reporting a drug, enter identifier N4, the 11-digit NDC, unit qualifier and number of units from the package of the dispensed drug in Form Locator 43 for the specified detail line. Do not enter a space, hyphen or other separator between N4, the NDC, the unit qualifier and the number of units. The NDC must be entered with 11 digits in a 5-4-2 digit format. The first 5 digits of the NDC are the manufacturer's labeler code, the middle 4 digits are the product code and the last 2 digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows: • For a 4-4-2 digit number, add a 0 to the beginning. • For a 5-3-2 digit number, add a 0 as the 6th digit. • For a 5-4-1 digit number, add a 0 as the 10th digit. Enter the unit qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The unit qualifiers are: • F2—International unit • GR—Gram • ML—Millimeter • UN—Unit

Field locator	Title	Action
44	HCPCS/Rates/Health Insurance Prospective Payment System (HIPPS) rate codes	Inpatient: This is required for inpatient newborn hearing screening services. When revenue code 0471 is entered in Form Locator 42, enter the appropriate hearing screening CPT code that best describes the service rendered. They are 92585, 92587, 92585-TC and 92587-TC. For details on inpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750 and 0790, see the instructions for Form Locator 74. Outpatient: Enter the 5-digit CPT-4 lab code from the Outpatient Hospital Laboratory Fee Schedule when billing for laboratory revenue codes (0300–0314). Do not bill radiology services with CPT codes. Radiology services performed by hospitals are billed by revenue code only. Revenue codes 0360, 0361, 0722, 0750 and 0790 require the entry of an HCPCS/CPT procedure code. Revenue code 0471 requires the entry of 1 of the following newborn hearing screening codes in this form locator: 92585, 92587, 92588, 92585 TC, 92587-TC or 92588-TC. Revenue code 0451 requires the entry of CPT code 99281 (emergency room screening and evaluation). Bill 0451 (99281) when the recipient had to be screened per the Emergency Medical Treatment and Labor Act (EMTALA) but required no further emergency room services. Centers for Medicare & Medicaid Services (CMS)-designated provider-administered drugs, for which the NDC is reported, require the entry of the appropriate HCPCS code. Freestanding dialysis centers: Claims for the administration of erythropoietin (Epogen, EPO) require the entry of the 5-digit injection HCPCS code. When billing for drugs and biologicals, the 11 digit NDC is required in Form Locator 43 along with the 5-digit HCPCS code in Form Locator 44. (See Form Locator 43 for instructions on entering the 11-digit NDC on the claim.) Hospice: When billing revenue center code 0657, enter the corresponding 5-digit CPT-4 code that is in the Florida Medicaid Hospice Coverage and Limitations Handbook. No other codes are covered. Long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry is required.

Field locator	Title	Action
45	Service date	Required on outpatient claims. Lines 1–22: On each line, enter the date of service. Line 23: On each page, enter the date the bill was created or prepared for submission in MMDDYY format.
46	Units of service	This form locator will accept up to 7 characters. Leading zeros are not required. Inpatient: Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day. Outpatient: Enter the units of service for each revenue code. Hospice: Enter the number of units of service for each type of service. Units are measured in days for codes 0651, 0655, 0656 and 0659; in hours for code 0652; and in procedures for 0657. Freestanding dialysis centers: Enter the units of service for the revenue center code(s). For revenue center codes 0821 and 0831, units are measured in the number of dialysis treatments the patient received in the billing period. Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the number of days associated with each revenue code. Medicaid reimburses the date of admission but not the date of discharge. Include the date of admission, but do not include the date of discharge in the total number of days. If the recipient is admitted and discharged on the same day, count it as 1 day.
47	Total charges	Inpatient, outpatient, hospice, freestanding dialysis centers: Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001. Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Do not deduct the patient responsibility. Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001.

Field locator	Title	Action
47	Total charges (continued)	For Medicare crossover claims (level of care X), compute the total charge using the Medicare rate instead of the Medicaid per diem. If the Medicare rate for a recipient changed during the month, use the weighted average. The Medicare rate is weighted based on the number of days each rate is paid).
48	Noncovered charges	Inpatient: No entry required. Outpatient, hospice and freestanding dialysis centers: Enter the total payment received or expected to be received from a primary insurance payer identified in Form Locator 50A. Enter each portion of the payment applicable to each code in Form Locator 48. Enter the total amount of payment received or expected to be received from a primary insurance payer on the final page of the claim in Line 23. If the primary insurance payer other than Medicare pays a lump sum payment, enter a prorated amount on each line. If there is more than 1 other private payer, lump all amounts together in Form Locator 48 and attach each company's Explanation of Benefits (EOB) or remittance. Electronic software allows separate entries on an outpatient claim for primary, secondary and tertiary payer payments. If billing on a paper claim and there is more than 1 private payer, attach documentation to show how much each payer paid for each line item. Long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry is required.
49	Unlabeled	No entry required.
50A–C	Payer name	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter "Florida Medicaid" for the Medicaid payer identification. Enter the name of the third-party payer if applicable: • 50A—Primary payer • 50B—Secondary payer • 50C—Tertiary payer
51A–C	Health plan ID	For Medicaid, leave blank. If the health plan in Form Locator 50 has a number, report the number in 51A, B or C depending on whether the insurance is primary, secondary or tertiary.

Field locator	Title	Action
52A–C	Release of information	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): Indicate whether the patient or patient's legal representative has signed a statement permitting the provider to release data to other organizations. The Release of Information is limited to the information carried in this claim. A = Primary B = Secondary C = Tertiary code structure I = Informed consent to release medical information for conditions or diagnoses regulated by federal statutes (This is required when the provider has not collected a signature and state or federal laws do not supersede the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule by requiring a signature be collected.) Y = Yes, provider has signed statement permitting release of medical billing data related to a claim (This is required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.)
53A–B	Assignment of benefits	No entry required.
54A–C	Prior payments	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the amount the provider has received toward payment of this bill prior to the billing date on this claim. Do not put the Medicaid amount due in this form locator. Inpatient and outpatient: If no payment was received or if the service was denied, attach a copy of the EOB from the insurance carrier with the reason for denial.
55A–C	Estimated amount due	No entry required.
56	NPI	The NPI is a unique HIPAA-mandated number assigned to the provider submitting the bill. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57. If the provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code B3 and the taxonomy code in Form Locator 81. Entry of the NPI on paper claims is optional. Florida Medicaid prefers that the provider continue to enter Medicaid provider numbers on paper claims.

Field locator	Title	Action
57A–C	Other provider ID	Use of an identification number other than NPI is being reported. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57.
58A–C	Insured's name	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the insured's last name, first name and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility. If the recipient is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried.
59A–C	Patient's relationship	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter the code indicating the relationship of the patient to the identified insured. Line A: Primary payer, required Line B: Secondary payer, situational Line C: Tertiary payer, situational code structure: 01 = Spouse 18 = Self 19 = Child 21 = Unknown
60A–C	Insured's unique ID	Inpatient, outpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter all of the insured's unique identification numbers assigned by any payer organizations, including Humana's member ID, beginning with "H." The recipient's 10-digit Medicaid ID must be verified and entered. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B or C. If Medicaid is primary, enter the recipient's Medicaid ID in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID in Form Locator 60B.
61A–C	Insurance group name	No entry required.
62A–C	Insurance group name	No entry required.

Field locator	Title	Action
63A–C	Treatment authorization code	Inpatient—MediPass: If a recipient younger than 21 is in the Children's Medical Services (CMS) network and the MediPass PCP authorized the services being billed, enter the 9-digit MediPass authorization number that was given to the hospital in Form Locator 63A. This number is different from the 10-digit prior authorization number issued by the Peer Review Organization (PRO) for inpatient services. If the recipient in the CMS network is admitted due to an emergency, no MediPass authorization number is required in this form locator. This requires type of admission code 1 or 5 in Form Locator 14. A MediPass authorization number is not required for any type of inpatient admission for any other category of recipient, except for children in the CMS network. If there is authorization from the PRO, enter the prior authorization number that covers the authorized days in Form Locator 63A if Medicaid is the primary payer or in Form Locator 63B if Medicaid is the secondary payer. Most inpatient admissions require authorization from the PRO before Medicaid payment can be made. However, there are several exemptions from inpatient authorization. An exemption from authorization allows Medicaid to pay an inpatient claim without authorization from the PRO and without a prior authorization number on the claim form. **Note:** See Chapter 3 in this manual for information on the types of admissions and recipient categories that require inpatient authorization and the listing of recipient categories and circumstances that are exempt from authorization. Inpatient—Psychiatric or substance abuse: When the admitting and primary diagnosis code is in the range of 290–314.9 or 648.30–648.44, prior authorization by the psychiatric PRO is required. Enter the prior authorization number that covers this hospitalization in Form Locator 63A if Medicaid is the primary payer or in 63B if Medicaid is the secondary payer. **Note:** See Chapter 3 in this manual for information on inpatient psychiatric or substance abuse authorization requirements. Outpatient: Outpatient services to recipients enrolled in MediPass require authorization from the MediPass PCP before services can be rendered, if the outpatient encounter

Field locator	Title	Action
63A–C	Treatment authorization code (continued)	is not an emergency. Enter the MediPass authorization number in Form Locator 63A if Medicaid is the primary payer or in 63B if Medicaid is the secondary payer. MediPass authorization is not required for true emergencies. This is indicated by the code entry of 1 or 5 for type of admission in Form Locator 14. It also is not required for emergency room screening and evaluation services required by the EMTALA, billed using revenue code 0451 with HCPCS 99281. Hospice: No entry required. Freestanding dialysis centers: No entry required. Long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required.
64A–C	Document control number	No entry required. If the claim is an adjustment or void of a previously paid claim, enter the 13-digit internal control number in Form Locator 80 in Line 2.
66	Diagnosis and procedure code qualifier (ICD version indicator)	Enter the qualifier that identifies the version of the ICD reported: • 9–9th Revision • 0–10th Revision
67	Principal diagnosis	This form locator is optional; it is not entered in the Florida Medicaid Management Information System. Inpatient and hospice: Enter the most specific 4th- and 5th-digit ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization or need for hospice care) that exists at the time of admission or develops subsequently that has an effect on the length of stay. Psychiatric admissions require the entry of a diagnosis in the range of 290–314.9 or 648.30–648.44 in this form locator and in Form Locator 69. A prior authorization number from the psychiatric PRO is required when the principal diagnosis is in the ranges noted here. If Medicaid is primary, the psychiatric PRO issued prior authorization number is entered in Form Locator 63a; if Medicaid is secondary, the prior authorization number is entered in Form Locator 63b. Outpatient: Enter only the most specific ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the use of hospital services that exist at the time of service).

Field locator	Title	Action
67	Principal diagnosis (continued)	Freestanding dialysis centers: Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for dialysis services. For example, enter diagnosis code 585.6 for end-stage renal disease. Long-term care facilities (skilled nursing facilities and ICFs/DDs): Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for long-term care. Long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required. Special circumstances when diagnosis codes are not required on outpatient claims: Diagnosis codes are not required on outpatient claims when the type of bill is 141 (hospital-referenced diagnostic services) or when either of the following occurs: • The only revenue center codes on the claim are in the range of 0300–0307. • The only revenue center codes on the claim are any 1 or any combination of the following (with any type of admission code): 0310, 0311, 0312, 0314, 0320, 0321, 0322, 0323, 0324, 0340, 0341, 0400, 0401, 0402, 0460, 0610, 0611, 0612, 0730, 0731, 0740.
67A–Q	Other diagnoses	Enter diagnoses that are other than the principal diagnosis. Inpatient: Enter the most specific ICD diagnosis codes corresponding to additional conditions that coexist at the time of admission or developed subsequently and had an effect on the treatment received during the length of stay. Outpatient: Enter the most specific ICD diagnosis codes that correspond to additional conditions that coexist at the time of service. Inpatient and outpatient: Present on Admission (POA) indicator: The POA indicator applies to diagnosis codes, not only on the conditions known at the time of admission but also to include those conditions that were clearly present, but not diagnosed, until after the admission took place. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including in the emergency department, are considered as present on admission. The

Field locator	Title	Action
67A–Q	Other diagnoses (continued)	POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The 5 reporting options for all diagnosis reporting are as follows: Y = Yes N = No U = No information in the record W = Clinically undetermined Unreported—Not Used = Exempt from POA reporting Hospice: No entry required. Freestanding dialysis centers: Enter the most specific ICD diagnosis codes that correspond to additional conditions that coexist at the time of service. Long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required. Special circumstances when diagnosis codes are **not** required on outpatient claims: Diagnosis codes are not required on outpatient claims when the type of bill is 141 (hospital-referenced diagnostic services) or when either of the following occurs: • The only revenue center codes on the claim are in the range of 0300–0307. • The only revenue center codes on the claim are any 1 or any combination of the following (with any type of admission code): 0310, 0311, 0312, 0314, 0320, 0321, 0322, 0323, 0324, 0340, 0341, 0400, 0401, 0402, 0460, 0610, 0611, 0612, 0730, 0731, 0740.
68	Unlabeled	No entry required.
69	Admitting diagnosis	Inpatient: Required for all inpatient claims and claims with type of bills (Form Locator 4): 011X, 012X, 018X and 021X. The presence of an admitting diagnosis in 290–314.9, or in the 648.30–648.44 range, psychiatric or substance abuse, indicates that the inpatient services needed authorization by the psychiatric PRO. Outpatient: This is required for outpatient to report the presenting symptom (diagnosis) and the reason for the patient's visit on claims that contain emergency services. Hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required.

Field locator	Title	Action
70A–C	Patient's reason for visit code	Outpatient: Enter the diagnosis codes describing the patient's reason at the time of the outpatient registration. This is required for all unscheduled outpatient visits as defined when the following occurs: Form Locator 4, type of bill 013X or 085X; Form Locator 14, type of admission codes 1, 2 or 5; and Form Locator 42, revenue codes 045X, 0516, 0526 or 0762 (observation room). Inpatient, hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICFs/DDs): No entry required.
71	Prospective payment system (PPS) code	No entry required.
72A-C	External cause of injury code	No entry required. **Inpatient and outpatient:** Enter the ICD diagnosis code pertaining to external cause of injuries, poisonings or adverse effects. Required when an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. **Inpatient and outpatient: POA indicator:** The POA indicator applies to diagnosis codes, not only on the conditions known at the time of admission, but also including those conditions that were clearly present, but not diagnosed, until after the admission took place. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The 5 reporting options for all diagnosis reporting are as follows: Y = Yes N = No U = No information in the record W = Clinically undetermined (Unreported—Not Used) = Exempt from POA reporting Hospice, freestanding dialysis and long-term care facilities (skilled nursing facilities and ICF/DDs): No entry is required.
73	Unlabeled	No entry required.

Field locator	Title	Action
74	Principal procedure code and date	Inpatient: Enter the code identifying the principal ICD surgical or obstetrical procedure and the date on which either was performed. Enter the date in MMDDYY format. False labor does not require a procedure code. A first surgical procedure code is required in this form locator when 1 of the following revenue codes is reported: 0360, 0361, 0722, 0750 or 0790. Outpatient: For details on outpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750 or 0790, see the instructions for Form Locator 44. Hospice: No entry required. Freestanding dialysis centers: No entry required. Long-term care facilities (skilled nursing facilities and ICF/DDs): No entry required.
74A-E	Other procedure codes and dates	Inpatient: Enter the codes identifying all significant procedures other than the principal procedure performed during the billing period covered by this bill and the dates on which the procedures were performed. Hospice, freestanding dialysis centers and long-term care facilities (skilled nursing facilities and ICF/DDs): No entry required.
75	Unlabeled	No entry required.
76	Attending provider name and identifiers	Enter the identifying information for the attending provider (the provider primarily responsible for the care of the patient) or the resident provider. Identifying information of advanced registered nurse practitioners may also be reported in this form locator if they were primarily responsible for services in the hospital setting. Entry of the NPI is optional; but the Qualifier 0B (for state license number) must be entered in the small field to the right of "QUAL," and the state license number must be entered in the larger field. Enter the license information in the following manner: ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending provider ID number.

Field locator	Title	Action
77	Operating provider name and identifiers	Required when a surgical procedure code is listed on the claim. Enter the identifying information for the surgeon. Entry of the NPI is optional, but the Qualifier 0B (for state license number) and the state license number must be entered. Enter the license information in the following manner: ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending provider ID number.
78-79	Other provider name and identifiers	Enter the identifying information for the other provider. Entry of the NPI is optional, but the Qualifier 0B (for state license number) and the state license number must be entered. Enter the license information in the following manner: ME9999999 with no spaces. On out-of-state claims, enter ME7777777 for the attending provider ID number. Inpatient and outpatient: If more than 1 provider performed the principal procedure or a different individual performed a secondary surgical procedure, report the other provider. Outpatient: If the referring provider is different than the attending provider, report the referring provider's information. Hospice: No entry required. Freestanding dialysis centers: No entry required. Long-term care facilities (skilled nursing facilities and ICF/DDs): No entry required.
80	Remarks (Financial Classification Code)	This field has 3 lines. Line 1: Financial Classification Code. Enter "FC" followed by the 3-digit Financial Classification Code in Line 1 of Form Locator 80. This code identifies the relationship of the payers indicated in Form Locators 50 A-C. The FC code is as follows: 1st position = Form Locator 50A primary payer code 2nd position = Form Locator 50B secondary payer code 3rd position = Form Locator 50C tertiary payer code Payer Codes: **0** No payer **1** Medicaid **2** Private Insurance **3** Blue Cross **4** Employer or Union (The FC code may be entered on the same line as "Remarks" or the line below.) **5** Medicare Part B **6** Other State Agency **8** No hospice patient resp. **9** Other

Field locator	Title	Action
80	Remarks (Financial Classification Code) (continued)	Example of FC codes: 100 – Straight Medicaid claim, claim with third party insurance denial attached, claim to which third party insurance applied all the payment to the deductible and a hospice claim with patient responsibility 180 – Claim with no hospice patient responsibility 210 – Claim with private insurance as the primary payer over Medicaid 310 – Claim with private Blue Cross® insurance as the primary payer over Medicaid 510 – Medicare Part B only (Inpatient Claim) 910 – Medicare crossover claims with other third-party payments Line 2: If you are adjusting or voiding the claim, enter the Internal Control Number (ICN) in Line 2. For a claim that was processed prior to July 1, 2008, that has a 17-digit Transaction Control Number (TCN), enter the TCN. Enter the Financial Classification Code that indicates you are adjusting or voiding the claim in Line 1. (Be sure the correct type of bill code is entered in Form Locator 4.) See Appendix A for the ICN Regions Codes. Line 3: Enter "Crossover" on Medicare crossover claims without third-party liability payment.
81A-C	Code-Code Field	If an NPI is entered in Form Locator 56 and the provider's NPI is mapped to a taxonomy code needed to identify the provider in the Florida Medicaid claims processing system, the provider must enter qualifier code B3 and the taxonomy code in this form locator.
81D	Code-Code Field	Long-term care facilities (skilled nursing facilities and ICF/DDs): In the first field, enter Qualifier Code 02. In the second field, enter the established level-of-care code to indicate the type of care that the recipient has been determined to require: 1 = Skilled 2 = Intermediate I 3 = Intermediate II 4 = State Mental Health Hospital

Field locator	Title	Action
81D	Code-Code Field (continued)	6-9 = ICF-DD Levels of Care H = AIDS Per Diem U = Skilled Fragile Children Under 21 X = Medicare Part A Coinsurance Payment In the third field, enter the facility's per diem. For level of care X, enter the respective Medicare per diem.

*FECA stands for Federal Employees' Compensation Act.
†NUCC stands for National Uniform Claim Committee.