

Mississippi Medicaid

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Bulletin

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Innovative State Use of the Civil Money Penalty Funds – Incentives for High Quality Care Enhancement Grant Award and Education Program Award

The deadline for submission of grant applications is January 15, 2004. Application requirements are located on the Division of Medicaid website as follows: www.dom.state.ms.us. At the “select a link”, choose Civil Money Penalty (CMP) Funds. A summary of each grant is provided below. If you have any questions, contact Evelyn Silas, Division Director, Institutional Long Term Care, at 601-359-6750.

Enhancement Grant Award: The goal is to provide enhancements to nursing facilities that have maintained compliance with the federal requirements for long-term care. The purpose of the Enhancement Grant Award is to provide a nursing facility with current and past compliance history of the federal requirements the opportunity to receive funding for innovative programs/projects that will directly and/or indirectly benefit the residents by providing an enhanced quality of life. The grant award should be self-sustaining once implemented. For FY 05, **\$250,000** has been set aside to award grants in the range of \$5000 - \$50,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application to DOM is **January 15, 2004**. The grants shall be awarded on or before **April 1, 2004**.

Educational Program Award: The goal of this Educational Program Award is to assist nursing facilities that have not been in substantial compliance with federal requirements for long-term care facilities to obtain and maintain compliance. The purpose of the Educational Program Award is to provide a nursing facility with current and past non-compliance history of the federal requirements the opportunity to receive funding for educational programs/projects that will directly and/or indirectly benefit the residents as well as assist the facility in providing an enhanced quality of life for the residents. These awards are available to facilities with current and past history of non-compliance with federal requirements. This grant award is a one-time expenditure that will benefit the residents. For FY 05, **\$100,000** has been set aside to award grants in the range of \$5000 - \$20,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application to DOM is **January 15, 2004**. The grants shall be awarded on or before **April 1, 2004**.



Guidelines for Adjusting/Voiding Claims After October 1, 2003

These guidelines apply for any claims that must be adjusted or voided regardless of the original date the claim was submitted.

- A claim originally submitted on paper can be adjusted electronically or by using a paper request.
- A claim originally submitted on paper can also be voided electronically or by using a paper request.
- A claim originally submitted electronically must be adjusted electronically.
- A claim originally submitted electronically can be voided electronically or by using a paper request; however, an electronic claim cannot be adjusted on a paper request.
- If you want to adjust a claim that was originally submitted electronically using a paper request, you must file a void request. Once the void has processed, you can resubmit the claim either on paper or electronically with correct information. Please do not attach a corrected claim to a void request.

Providers Billing Electronically

Providers now have the ability to electronically adjust and void claims submitted electronically. Providers can either use the standard functionality in an 837-claim format or providers can use WINASAP2003 to void or adjust a claim. For providers using WINASAP2003, see the information below for guidance on submitting an adjustment or void electronically.

For providers using third party software, you have the following options for adjusting and voiding claims electronically:

1. You can consult with your software vendor or clearinghouse for instructions on how to use the 837 to adjust or void a claim.
2. You can use WINASAP2003 in addition to your practice management system. You must be enrolled with ACS EDI Gateway and have a submitter ID to use WINASAP2003. You may contact ACS EDI Gateway at 1-866-225-2502, Monday through Friday, 8:00 am to 6:00 pm EST, for additional information on enrolling with ACS EDI Gateway and using WINASAP2003 to adjust and void your claims electronically.

These same guidelines apply for providers who need to adjust or void claims that were originally submitted using NECS or WINASAP2000. WINASAP2003 can be used to submit electronic adjustments or voids of claims originally submitted using NECS or WINASAP2003.

The procedures for voiding and adjusting electronically submitted claims using WINASAP2003 are as follows:

Void Procedure:

- Copy claim that was originally submitted
- Locate ***Frequency type code***, located on the claim Data screen
- Indicate ***Void (Void/Cancel of prior claim)***
- Then transmit the claim

Adjustment Procedures: "Only to paid claims"

- Copy claim that was originally submitted
- Locate ***Frequency type code***, located on the claim data screen
- Indicate ***Initiated Adjust Claim***
- Then select ***Claim Information*** from the tabs above
- Find and indicate ***Other Subscriber Information***
- Select Other ***Subscriber Page 2***
- This page is where you will indicate the information that is applicable to the adjustment process
- Check ***Adjustment indicator to Yes***
- From the tabs below indicate ***Adjustment Info***
- Complete the fields that are related to the adjustment Claim
- ******Group Code/Reason Code/Adjustment Amount/Adjustment Units******

Provider Tax ID and Social Security Numbers on Provider File

A Medicaid provider **cannot** have a Social Security Number (SSN) and Tax Identification Number (TIN or EIN) associated with one Medicaid provider number.

All physicians, nurse practitioners, physician assistants, CRNAs, nurse midwives, dentists, psychologists, chiropractors, podiatrists, occupational therapists, physical therapists, speech/language therapists and social workers must have an individual Medicaid provider number. All individual provider files must be entered into the Medicaid system with the SSN of the individual.

If you are a physician, nurse practitioner, physician assistant, CRNA, nurse midwife, dentist, psychologist, chiropractor, podiatrist, occupational therapist, physical therapist, speech/language therapist, social worker, or any other individual provider with a provider number and you wish to have your Medicaid income reported to a TIN or EIN, you **must** obtain a group provider number and link your individual Medicaid provider number to the billing group. The billing group will bill Medicaid claims indicating the individual provider as the servicing provider. When Medicaid claims are paid, the "Pay To" provider will be that of the billing group provider with the TIN or EIN.

If you wish to verify that your Medicaid provider number has the correct SSN or TIN, you may do one of the following:

- Consult the Medicaid RA that has the provider number and the SSN or TIN to which the income is being reported.
- Consult the welcome letter that was mailed to you when the re-enrollment process was completed.
- Contact the ACS Provider and Beneficiary Call Center at 1-800-884-3222 or 601-206-3000.

Billing HCPCS Code J3490

HCPCS Code J3490 is the only HCPCS code reimbursed by Mississippi Medicaid for injectable drugs that do not have a specific HCPCS code. You must submit a paper claim with the name of the drug, strength, dosage and method of administration indicated by the code. Only one (1) unit can be billed with J3490. The claims will be reviewed by the fiscal agent Medical Review Unit and priced according to dosage administered to the patient.

Notice to NFs and ICF-MRs on X-ray and Lab Costs

X-ray and lab costs incurred by nursing facilities and intermediate care facilities for the mentally retarded are not allowable costs on the cost report, in accordance with Chapter 2, Section 2-1, B, 9 of Attachment 4.19-D of the Mississippi Medicaid State Plan. This includes services provided by Independent Diagnostic Testing Facilities or other independent mobile diagnostic units, including portable x-ray providers. Please refer to Section 37.02 of the Medicaid Provider Policy Manual for information on billing these services.

3-Digit vs. 4-Digit Revenue Codes

Currently, DOM and ACS only accept 3-digit revenue codes. If your software has a revenue code field which accepts a 4-digit revenue code, please work with your software vendor to ensure the software only outputs the true 3-digit revenue code.

Call Record Tracking Numbers

When calling the ACS Call Center, ask for the call record number (CRN) from the Call Center Associate prior to ending your call. Make a record of this number, as it will be useful if there is a need for you to follow up on an inquiry.

Billing Tip

Please remember not to highlight any information on your claims or attachments prior to submitting them to ACS for processing. All claims and attachments are scanned and anything highlighted scans as solid black, which prevents keyers from reading the information. If you need to identify specific information, it should be circled.

UB-92 and CMS-1500 Paper Claim Submission

Effective December 1, 2003, paper submissions of the UB-92 and CMS-1500 claim forms will be processed using Optical Character Recognition (OCR). OCR technology is widely accepted by commercial and governmental healthcare financing organizations. Mississippi Medicaid is implementing the technology in an effort to increase efficiency, accuracy, and more timely processing of Provider claims. OCR processing requires that claims be typewritten on “red drop-out” forms. UB-92 and CMS-1500 claim forms can be purchased from a variety of vendors including forms distributors, print vendors, and office supply companies.

Providers are encouraged to use typewritten “red drop-out” forms for all UB-92 and CMS-1500 paper claims submissions. Handwritten, photocopied, and other black and white formats will cause a delay in claim processing and payment.

Web Portal Registration

On October 6, 2003, the Mississippi Medicaid Web Portal was launched. The web portal provides another alternative to using the ACS Provider and Beneficiary Call Center or the Automated Voice Response System (AVRS). The website for the web portal is <http://msmedicaid.acs-inc.com>.

The web portal has two areas that can be accessed from the initial home page. One area is non-secure and allows access to the general public without registration. The second area is a secure website that requires registration and provides additional functionality that is associated with the Call Center and the AVRS.

The non-secure area allows the general public (provider and beneficiary) to access general Medicaid information, which includes Medicaid policy, provider publications, and RA banner messages. This area also allows a provider to access the late breaking news section, which identifies claims processing issues, Medicaid policy changes and system reprocessing information. Other commonly accessed features of the non-secure area are the Frequently Asked Questions (FAQs), Billing Tips and Ask Provider Relations sections.

Important Registration Information

- To register, the provider must provide the 8-digit Medicaid provider number, the corresponding Social Security number or tax identification number, and the last 5-digits of the bank account that is currently active on the provider's file.
- At registration, each provider must choose a unique user ID that the provider determines and a valid e-mail address. The password for the account that is registered is e-mailed to the address that is supplied at registration.
- A separate registration is required for each provider number. This is a security feature. Only the registered provider's information will be given when conducting provider inquiries for claims and payment.
- Group providers cannot add individual providers to their profile. The individual provider must register separately and then invite the group provider members to join their account by using the ‘Add Existing User’ feature.

Holiday Hours for Health Information Designs (HID)

HID will be closed on Christmas Day and New Year's Day. For emergency situations that cannot wait until the next day, call 1-800-355-0486 and follow the instructions.

Allowable Board of Directors' Fees for Nursing Facilities, ICF-MRs and PRTFs 2003 Cost Reports

The allowable Board of Directors' fees that will be used in the desk reviews and audits of 2003 cost reports filed by nursing facilities (NFs), intermediate care facilities for the mentally retarded (ICF-MRs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for All Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors' fees for 2003 are as follows:

Category	Maximum Allowable Category Cost for 2003
0 - 99 Beds	\$3,090
100 - 199 Beds	\$4,636
200 - 299 Beds	\$6,181
300 - 499 Beds	\$7,726
500 Beds or More	\$9,271

Hospice Program Update

The Division of Medicaid continues to work the backlog of enrollment and disenrollment forms received in the Hospice program. In order to assist in the processing of these applications, it is necessary to complete ALL portions of the enrollment (DOM-1165) and disenrollment (DOM-1166) forms. If any field is not applicable, please write or type N/A in that field. We will not consider incomplete forms for review.

Effective December 1, 2003, you must use the revised Hospice Enrollment and Disenrollment Forms. You may download the forms on the DOM website at:

http://www.dom.state.ms.us/Provider/Provider_Manuals/Section_14_Hospice_Manual.pdf.

If you have any questions concerning the Hospice program, please call the Bureau of Long Term Care at 1-800-421-2408 or 601-359-6141.

Mississippi Medicaid Hospice Membership Form

Upon completion of the form mail along with required supporting documentation (see section 14.03 of the Hospice policy manual) to:

Division of Medicaid
Long Term Care, Hospice Services
239 North Lamar Street
Robert E. Lee Bldg. Suite 801
Jackson, MS 39201-1399

**Instructions for Completing the Mississippi Medicaid Hospice Membership Form:**

- (1) Complete the individual's name **exactly** as it appears on his/her Medicaid card.
- (2) Complete the Medicaid number **exactly** as it appears on his/her Medicaid card.
- (3) Complete the individual's Social Security number **exactly** as it appears on his/her Medicaid card.
- (4) Complete the individual's Medicare number **exactly** as it appears on his/her Medicare card.
- (5) Complete the individual's date of birth.
- (6) Complete the individual's area code and phone number.
- (7) Complete the individual's street address.
- (8) Complete the individual's city, state, and zip code.
- (9) Complete the name of parent, legal guardian, or representative (if applicable).
- (10) Complete by checking the appropriate box for the hospice benefit period and fill in requested effective date of segment.
- (11) Complete the hospice's Medicaid provider name
- (12) Complete the hospice's Medicaid provider number.
- (13) Complete the name of the nursing facility where the beneficiary resides (if applicable).
- (14) Complete the nursing facility's Medicaid provider number (if applicable).
- (15) Complete the attending physician's name.
- (16) Complete the county where actual services will be rendered.
- (17) Complete the "group rate" code (refer to section 14.11 of the Hospice manual).
- (18) Have the provider's representative sign the form.
- (19) Have the provider's representative date the form.

Election Statement: Allow individual or representative time to read closely. Have individual or representative sign indicating Enrollment or Disenrollment into the hospice program. **The hospice provider's representative who is present must sign as the witness.**

Election Statement



The Mississippi Medicaid Hospice Care Services program has been explained to me. I have been given the opportunity to discuss the benefits, requirements, and limitations of this program and the terms of the election statement. I understand that by signing the election statement, I am waiving all rights to Medicaid for the duration of hospice care for the following services:

1. Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice) and;
2. Any Medicaid services that are related to the treatment of the condition, or a condition, for which hospice care was elected or that are equivalent to hospice care with the following exception: services provided by my attending physician (if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services).

I understand that I will be entitled to Medicaid hospice care coverage for the enrolled benefit segment as long as I am Medicaid eligible.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date. I understand my rights to other Medicaid services will resume at that time, if I continue to be Medicaid eligible.

I understand that I may change the designated hospice provider without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received.

Beneficiary Name	Beneficiary Medicaid Number

Address (Street Address, City, State and Zip Code)

By signing this statement, I am electing the above named hospice to provide me with the services of the Medicaid hospice care program.

Beneficiary/Representative's Signature	Date

Provider Signature (Must be present)	Date

Provider Name	Provider Number

DOM USE ONLY

Approving Authority's Signature	Date
	Effective Enrollment Date

Mississippi Medicaid Hospice Membership Enrollment Form

To be completed upon enrollment. Please print in ink or type. See instructions.



Beneficiary Information

Name (Last, First and Middle Initial)

1.)

Medicaid #

Social Security #

2.)

Medicare ID#

3.)

Date of Birth

4.)

Home Phone Number

5.)

Street Address

6.)

City, State and Zip Code:

7.)

8.)

Parent/Legal Guardian or Representative and Relationship:

9.)

10.) Hospice Benefit Period:

First 90 Day Segment

Second 90 Day Segment

60 Day Period

Requested effective date of segment: _____

Provider Information

Hospice Provider Name

Hospice Medicaid Provider #

11.)

12.)

Nursing Facility Where Beneficiary Resides (if applicable)

13.)

Nursing Facility Medicaid Provider # (if applicable)

14.)

Attending Physician's Name:

15.)

County Where Services Will Be Rendered:

16.)

Group Rate Code

17.)

Provider Signature

Date

18.)

19.)

DOM USE ONLY

Approving Authority's Signature

Date

Effective Enrollment Date

Mississippi Medicaid Hospice Membership Disenrollment Form

To be completed upon disenrollment.



Instructions for Completing the Mississippi Medicaid Hospice Membership Disenrollment Form:

1. Enter the Beneficiary's name exactly as it appears on his/her Medicaid ID Card.
2. Enter the Beneficiary's Medicaid ID #
3. Enter the Beneficiary's Social Security Number.
4. Enter the Hospice provider name.
5. Enter the Hospice Provider's Medicaid ID#
6. Enter the effective date of disenrollment.
7. Indicate the reason for disenrollment. If 6 (other), please explain.
8. Allow the beneficiary or representative time to read the form. Have the individual sign and date the form.
9. Have the provider's representative sign and date the form.
10. Forward immediately to:

Division of Medicaid
Long Term Care, Hospice Services
239 North Lamar Street
Robert E. Lee Bldg. Suite 801
Jackson, MS 39201-1399

Mississippi Medicaid Hospice Membership Disenrollment Form

To be completed upon **disenrollment**. Please print in ink or type. See instructions.

Beneficiary Information

Name (Last, First and Middle Initial)

1.)

Beneficiary's Medicaid ID#

Beneficiary's SS#

2.)

3.)

Hospice Provider's Name

4.)

Hospice Provider's Medicaid ID#

Effective Date of Disenrollment

5.)

6.)

7.) Reason for Disenrollment:

1 Voluntary disenrollment

4 Seeking treatment other than palliative in nature

2 No longer meets hospice requirements

5 Death

3 Hospitalization unrelated to terminal illness

6 Other _____

THIS DISENROLLMENT FORM MUST BE COMPLETED, SIGNED, AND SUBMITTED TO THE DIVISION OF MEDICAID WITHIN 48 HOURS OF THE DISENROLLMENT, OR THE HOSPICE WILL BE RESPONSIBLE FOR ANY OR ALL CHARGES INCURRED BY THE BENEFICIARY.

The individual forfeits coverage for any remaining days in that election period. An individual may not designate an effective date earlier than the date that the revocation was made.

Upon revoking the election of Medicaid coverage of hospice care for this particular election, I understand that I resume Medicaid coverage of benefits waived when hospice care was elected, providing I remain eligible for Medicaid coverage. I also understand that I can re-elect hospice coverage for any other hospice benefits for which I am eligible.

Signature of Beneficiary/Representative

Date

8.)

Signature of Hospice Representative

Date

9.)

DOM USE ONLY

Approving Authority's Signature

Date

Effective Disenrollment Date

Pharmacy Program Updates for Pharmacies and Prescribers

Co-Payments

When a beneficiary is exempt from rendering co-payment, the exception code must be indicated in the Medicaid ID number field as a suffix to the Medicaid number. Otherwise, co-payment will be deducted from the claim's payment amount. To use the pregnant women exception code, the prescribing physician must boldly indicate a "P" on the prescription.

Prescriptions for Newborns

Physicians who write a prescription for a newborn must clearly indicate "newborn" on the prescription. Pharmacists must clearly use the baby's name, the mother's Medicaid ID number, and the infant exception code (K) when filing a claim for these prescriptions. The use of the mother's ID number with a "K" suffix is temporary for each newborn. Pharmacists should call the AVRS at 1-800-884-3222 when a newborn is over 30 days old to obtain the baby's Medicaid ID number.

Compounding

The Mississippi Division of Medicaid does not reimburse for compounding other than hyperalimentation or total parenteral nutrition.

NCPDP Reject code 76 signifies Maximum Daily Dose or Plan Limitations Exceeded. In accordance with State law, the Division of Medicaid's policy states that a pharmacist may not bill for a quantity that exceeds a 34-day supply. In order to allow for more accurate billing of a 34-day supply, an edit has been implemented regarding maximum dosing. The Division of Medicaid will allow a prescription to be billed at 150% times the maximum dose calculation as determined by the Federal Drug Administration and the manufacturer's recommended maximum total daily dose and supplied to First DataBank. If a beneficiary requires more than this amount, the prescriber must request an exception override of this requirement by seeking approval from Health Information Designs (HID). A copy of the maximum request override form may be accessed in the November 2003 bulletin or found on the HID web site at www.hidmsmedicaid.com. Please note that supporting documentation must be in beneficiary's medical record to substantiate a request for total maximum daily dose in excess of recommended maximum dose. Approval will not be granted for non-FDA approved indications.

*New Monthly Maximum Quantities for Inhalers/Inhalation Solutions**

Drug Name	Maximum Monthly Quantities
AccuNeb (0.63mg & 1.25 mg)/3ml	375ml (5 boxes)
Albuterol Inhaler	51 gm (3 Inhalers)
Albuterol 0.083%/3 ml Nebs	360ml (or 408ml/34days)
Advair Diskus(all strengths)	60 (1 box)
Atrovent Inhaler	42 gm (3 Inhalers)
Atrovent(Ipratropium) Nebs	300 ml (or 340ml/34 days)
Combivent Inhaler	29.4 gm (2 Inhalers)
DuoNeb(Ipratropium/Albuterol)	540 ml (or 612ml/34 days)
Flonase Nasal Spray	16 gm (1 Inhaler)
Flovent Inhaler (44mcg & 110mcg)	13 gm (1 Inhaler)
Flovent Inhaler (220mcg)	26 gm (2 Inhalers)
Flovent Rotadisk (All strengths)	120 (2 boxes)
Nasonex Nasal Spray	17gm (1 Inhaler)
Pulmicort Respules(All strengths)	120ml (2 boxes)(or 136ml/34days)
Serevent Diskus	60 (1 box)
Xopenex Nebs (All strengths)	288 ml (4 boxes)

*If higher dosage or quantities are indicated, the prescriber must submit a Maximum Unit Override Form to HID.

FAX TO: 1-800-459-2135

HEALTH INFORMATION DESIGNS, INC.
P.O. BOX 320506
Flowood, MS 39232
Phone: (800) 355-0486

**MAXIMUM UNIT OVERRIDE
REQUEST FORM**

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____
DOB: _____ City: _____
Month Day 4 Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ Medicaid ID #: _____
City: _____ State: _____ Phone #: _____
Fax #: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature and date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider ID# _____
City: _____ State: _____ Phone #: _____
Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity/Month: _____
Diagnosis: _____ Maximum Qty Requested: _____

Reason for Request:

List current dose strength: _____ mg List current dosing frequency: _____

Length of current therapy: _____ months

List requested dose strength: _____ mg List requested dosing frequency: _____

Medical Justification: _____

**Supporting documentation must be available in the patient record

FOR HID USE ONLY

Eligibility Verified by _____
Approved _____
Denied/Code: _____
From Date _____ Thru Date _____
Reviewed by _____
HID# _____ PA# _____

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Policy Manual and must be placed behind Tab 88 of the manual. All providers are held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

PRSR STD
 U.S. Postage Paid
 Jackson, MS
 Permit No. 53

ACS
 P.O. Box 23078
 Jackson, MS 39225

If you have any questions related to the topics in this bulletin, please contact ACS at 1-800-884-3222 or 601-206-3000

Mississippi Medicaid
 Bulletins and Manuals
 are on the Web
www.dom.state.ms.us

December

December 2003

<i>Sunday</i>	<i>Monday</i>	<i>Tuesday</i>	<i>Wednesday</i>	<i>Thursday</i>	<i>Friday</i>	<i>Saturday</i>
	1	2	3	4 EDI Cut Off 5:00 p.m.	5	6
7	8 CHECKWRITE	9	10	11 EDI Cut Off 5:00 p.m.	12	13
14	15 CHECKWRITE	16	17	18 EDI Cut Off 5:00 p.m.	19	20
21	22 CHECKWRITE	23	24 DOM and ACS CLOSED AT NOON	25 EDI Cut Off 5:00 p.m. DOM and ACS CLOSED	26 DOM and ACS CLOSED	27
28	29 CHECKWRITE	30	31			

Checkwrites and Remittance Advices are dated every Monday. However, funds are not transferred until the following Thursday, and Remittance Advices usually arrive the following Friday.

