



Paper Claims Billing Instructions

State of Mississippi, Office of the Governor, Division of Medicaid
(DOM)

Version 9.0

Change History

The following change history log contains a record of changes made to this document:

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	09/28/2022	Gainwell	Initial publication.
2.0	10/05/2022	Gainwell	Updated Figure 84. FL 39-41 Situational: Value Codes and Amounts.
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4.0	10/17/2022	Gainwell	Updated links in section 4.5.
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6.0	12/30/2022	Gainwell	Updated Figure 100. FL 57 Situational: Other (Billing) Provider Identifier and Updated Figure 125. to FL 81cc Required: Code-Code Field.
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8.0	03/10/2025	Gainwell	Updated title of document, section 4.8 Figure 35. FL22 Situational: Resubmission Code (Original Reference No.) instructions, section 4.8 Figure 36. FL 23 Situational: Prior Authorization Number instructions, section 6.5, section 6.8, and removed Acceptable values information listed at the end of document. Updated Figure 36. FL 23 Situational: Prior Authorization Number, Figure 83. FL 38. Situational: Responsible Party Name and Address, and Figure 192. ADA Dental Claim Form (Version 2012).
9.0	02/05/2026	Gainwell	Updated section 5.8 Figure 61 on page 24 to include 'physical' before address and add statement "P.O. Box Not Allowed" below the instructions.

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1. Introduction

The Paper Claims Billing Instructions document is designed to offer guidance and assistance to providers submitting claims for reimbursement to the Mississippi Division of Medicaid (DOM). The Paper Claims Billing Instructions includes detailed information specific to the submission of paper claims, which includes Centers for Medicare and Medicaid (CMS)-1500, Dental, and UB-04 claims. This document must be used in conjunction with the General Policy and DOM's Provider Specific Administrative Code. DOM policy is located at [Administrative Code](#) and [Mississippi Medicaid State Plan](#).

2. Mississippi DOM

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to needy citizens. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated DOM, in the Office of the Governor, as the single state agency responsible for administering the Medicaid program in Mississippi.

DOM can be contacted through the internet, by telephone, or by written correspondence. Providers may use the telephone numbers provided below to reach the DOM offices during business hours. The DOM website (<http://www.medicaid.ms.gov>) provides valuable and current information, such as provider fee schedules, provider billing handbook, Administrative Code, State Plan, and public notices.

2.1. Fiscal Agent

DOM presently works in conjunction with a fiscal agent (Gainwell) to provide accurate and efficient claims processing and payment. Both organizations work together to offer provider and beneficiary support to meet the needs of the Mississippi Medicaid community. The fiscal agent consists of technical and program staff. Technical staff maintains the claims processing operating system, and program staff assists with the actual processing of claims, payment, and customer service. Other functions include drug rebate analysis and utilization review.

DOM and Gainwell have several systems in place to make contacting the appropriate offices easier for providers. Having several different systems in place for providers to obtain needed information should decrease the time and effort required by providers to complete forms and meet requirements correctly and completely.

2.2. Telephone Contact

Gainwell provides telephone access to providers as shown in Table 1. These services include lines for provider inquiries, automated eligibility verification, and assistance with electronic claim submittal. The call center is open Monday through Friday, from 08:00 a.m. to 05:00 p.m. Central Standard Time (CST). The website includes a listing with the name and telephone number of the provider representative assigned to each area.

Table 1. Gainwell Telephone Numbers

Contact/Office	Telephone Numbers
Provider/Beneficiary Services	1-800-884-3222
Provider Services Fax Number	1-866-644-6148
Member Services Fax Number	1-866-644-6050
Automated Voice Response System (AVRS)	1-800-884-3222
Electronic Data Interchange (EDI)	1-800-884-3222
Pharmacy Call Center	1-833-660-2402
Pharmacy Prior Authorization Fax Number	1-866-644-6147

2.3. Mailing Contact Information

Providers may contact Gainwell via the mail at the addresses listed in Table 2. These post office boxes should be used for claim submittals, adjustments, and void requests. Correspondences should be sent to the appropriate post office box to lessen the chance for errors and shorten the time required to complete transactions.

Table 2. PO Box by Mail Type - Jackson

Jackson — Post Office™	Mail Type
PO Box 23076 Jackson, MS 39225	Paper Claims CMS-1500, UB-04, and Dental (including crossover claims)
PO Box 23077 Jackson, MS 39225	Paper Adjustment/Void Requests

3. Adjusting and Voiding Claims

DOM and Gainwell require providers to adjust and void claims. The following procedures allow providers to find solutions to payment difficulties and correct under/overpayments:

- Providers must submit an adjustment/void if paid incorrectly on the remittance advice (RA) for a Medicaid claim or if monies have been received from a third-party payer after payment from Medicaid. The adjustment/void must be submitted on the appropriate claim form (CMS-1500, UB-04, Dental).
- Providers may submit an adjustment/void claim to request an adjustment. Adjustment requests are used to change the original amount paid on a claim. The original payment can be increased or decreased. Void requests are used to refund the entire original payment on a claim.
- When refunding money to Medicaid, it is not necessary to remit a refund check.
 - If an adjustment results in a reduction in the original Medicaid payment and no refund check is included, an adjustment is made on the subsequent weekly RA.
 - If a refund check is included, the adjustment is applied against the refund check.
 - The only time the actual Medicaid check should ever be returned is in the rare event that all claims on the RA were paid incorrectly, and the entire amount is to be refunded.
- A denied claim must be resubmitted on the appropriate claim form, and the error must be corrected. The Explanation of Benefits (EOB) message on the RA provides guidance for submitting the corrected claim.
- If an adjustment appears on a RA and is not correct, another adjustment request may be submitted using the Internal Control Number (ICN) from the debit line of the adjusted claim.
- Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted as a new day claim.

3.1. Completing the Adjustment/Void Request Claim (CMS-1500, UB-04, ADA 2012)

Instructions for completing the adjustment/void claim are described in each of the corresponding claim sections.

4. CMS-1500 Claim Form Instructions

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the CMS-1500 billing form and must be used in conjunction with the Mississippi Administrative Code Title 23. Professional providers are strongly encouraged to bill electronic claims to reduce the potential for errors and speed reimbursement. The Administrative Code and fee schedules should be used as a reference for issues concerning policy and the specific procedures for which Medicaid reimburses. Contact the fiscal agent's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222 for questions and assistance.

4.1. Provider Types

The instructions for the CMS-1500 claim form are to assist the following types of providers:

- Ambulance
- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetists
- Chiropractic Care
- Community/Private Mental Health Centers
- Durable Medical Equipment (DME)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening Providers
- Federally Qualified Health Centers
- Hearing Aid Providers
- Independent Laboratory
- Independent Radiology
- Mental Health Services
- Nurse Practitioners
- Optical/Vision Providers
- Perinatal High-Risk Management
- Pharmacy Disease Management
- Physicians
- Physician Assistants
- Podiatrists
- Prescribed Pediatric Extended Care
- Private Duty Nursing
- Rural Health Clinics
- Therapy Services (physical, occupational, and speech)
- Waiver Services

4.2. MESA Web Portal Reminder

Providers are encouraged to use the MESA Web Portal for easy access to up-to-date information. The MESA web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The MESA web portal is available 24 hours a day, seven days a week, 365 days a year via the Internet at <https://portal.ms-medicaid-mesa.com/MS/Provider>.

4.3. Paper Claim Guidelines

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- An original CMS-1500 claim form must be completed.
- No photocopied or fax claims are accepted.
- Do not include handwritten information on the claim form.
- Blue or black ink must be used to fill out the form.
- The information on the form must be legible.
- No highlighters should be used.
- Correction fluid or correction tape should not be used.
- Names, codes, numbers, etc. must print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- The six service lines in Locator 24 have been divided horizontally to accommodate submission of supplemental information along with NPI and other identifiers such as taxonomy codes or legacy identifiers. The top, shaded portion of each service line is for reporting supplemental information (i.e., National Drug Code (NDC)). It is not intended to allow the billing of twelve service lines. Each procedure, service, drug, or supply must be listed on its own claim line in the bottom, unshaded portion of the claim line.

4.4. Paper Claims with Attachments

When submitting attachments with the CMS-1500 claim form, the below guidelines should be followed:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim on standard 8½-by-11-inch paper.
- For claims with third-party payor source, all EOBs that relate to the claim must be included.
- Do not use red ink on the attachment

4.5. Multi-Page Paper Claims

When submitting CMS-1500 claims with multiple pages, the below guidelines should be followed:

- Multi-page claims are limited to 9 pages with a maximum of 50 claim lines. The 9th page should only be used to bill two detail lines.
- The first form should not be totaled. The total should be indicated on the last page. Amounts totaled on the first form will result in claim denial(s).
- Pages together must be clipped together.

- Indicate Multipage Page count X of 9 in [FL 19 \(Figure 32\)](#).
- If reporting a Third-Party Liability (TPL) payment, indicate it in [FL 29 \(Figure 51\)](#) of the last page.
- Only one copy of an attachment (e.g., EOB, EOMB, and Consent Form) is required per claim.

4.6. Electronic CMS-1500 Claims

Electronic CMS-1500 claims may be submitted to Mississippi Medicaid by:

- Using the Web Portal Claims Entry feature
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid

Electronic CMS-1500 claims must be submitted in a format that is Health Insurance Portability and Accountability Act (HIPAA) compliant with the American National Standard Institute (ANSI) X12 837P claim standards.

4.7. Claim Mailing Address

Once the claim form has been completed and checked for accuracy, the completed claim form can be mailed to:

Mississippi Medicaid Program

PO Box 23076

Jackson, MS 39225-3076

4.8. CMS-1500 Claim Form Instructions (Version 02/12)

On August 01, 2014, Mississippi Medicaid began receiving and processing paper claims submitted only on the revised CMS-1500 Claim Form (version 02/12). The field instructions are as follows.

Figure 1. FL 1 Required: Type of Insurance

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input checked="" type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)
---	---	--	--	---	---	---

Instructions: Indicate the type(s) of insurance coverage applicable to this claim. Enter an "X" in the box marked Medicaid.

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)
--	--	--	--	---	---	---

Instructions: Indicate the type(s) of insurance coverage applicable to this claim. Enter an "X" in the box marked Medicare for claims where the member has Medicare Coverage.

Figure 2. FL 1a Required: Insured's ID Number

1a. INSURED'S I.D. NUMBER 123456789	(For Program in Item 1)
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Instructions: Enter the member's nine-digit identification number as listed on their Medicaid card.

Figure 3. Example of Insured's Medicaid ID Card



Figure 4. FL 2 Required: Patient Name

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, John B.

Instructions: Enter the member's name as it appears on the Medicaid ID card in the last name, first name, and middle initial format. Mismatched names will result in claim denial(s).

Figure 5. FL 3 Required: Patient Birth Date, Sex

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY	M	F
01	01	1991	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Instructions: The date format is eight digits MM/DD/CCYY (e.g., 01011991). Enter the month, day, and year of birth of the member. If the full birth date is unknown, indicate zeros for all eight digits.

Enter the sex of the patient. If Sex is Unknown, do not mark either the "F" or "M" box

- F – Female
- M – Male
- U – Unknown

Figure 6. FL 4 Not Required: Insured Name

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Instructions: Leave this field blank.

Figure 7. FL 5 Not Required: Patient Address

5. PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)
	()

Instructions: Leave this field blank.

Figure 8. FL 6 Not Required: Patient Relationship

6. PATIENT RELATIONSHIP TO INSURED							
Self	<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Child	<input type="checkbox"/>	Other	<input type="checkbox"/>

Instructions: Leave this field blank.

Figure 9. FL 7 Not Required: Insured Address

7. INSURED'S ADDRESS (No., Street)

Instructions: Leave this field blank.

Figure 10. FL 8 Not Required: Reserved for NUCC USE

8. RESERVED FOR NUCC USE

Instructions: Leave this field blank.

Figure 11. FL 9 Situational: Other Insured Name

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, Mary A.

Instructions: Enter the last name, first name, and middle initial format of the member if different than shown in [FL 2 \(Figure 4\)](#). The other insured name indicates that there is a holder of another policy that may cover the patient.

Figure 12. FL 9a Situational: Other Insured Policy or Group Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER
72431

Instructions: Enter policy number of the other insured as it appears on the insured's Insurance ID card. If group number is available, enter both.

Note: The policy number is used to verify the policy by the Office of Third Party Liability/Recovery, when applicable.

Figure 13. FL 9b Not Required: Reserved for NUCC Use

b. RESERVED FOR NUCC USE

Instructions: Leave this field blank.

Figure 14. FL 9c Not Required: Reserved for NUCC Use

c. RESERVED FOR NUCC USE

Instructions: Leave this field blank.

Figure 15. FL 9d Situational: Insurance Plan Name or Program Name

d. INSURANCE PLAN NAME OR PROGRAM NAME Merit Insurance

Instructions: Enter the other insured's insurance plan or program name.

Figure 16. FL 10a-c Situational: Is Patient's Condition Related To:

- a. Employment?
- b. Auto Accident?
- c. Other Accident?

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
b. AUTO ACCIDENT?	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO PLACE (State) <input type="text"/>
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

Instructions: Check the appropriate box to indicate whether one or more of the services described in FL 24 a-j (Figures 37-46) are for a condition or injury that occurred on the job or as a result of an auto accident or other accident.

Note: Enter the State code if 10b. is checked "YES". Any item checked "YES" indicates there may be other insurance primary to Medicaid. Identify primary insurance information in [FL 11 \(Figure 18\)](#).

Figure 17. FL 10d Situational: Claim Codes

10d. CLAIM CODES (Designated by NUCC) AI

Instructions: When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the National Uniform Claim Committee (NUCC) under Code Set <https://www.nucc.org/>.

Figure 18. FL 11 Situational: Insured's Policy Group or Federal Employees Compensation Act (FECA) Number

11. INSURED'S POLICY GROUP OR FECA NUMBER 15974
--

Instructions: Enter the insured's policy or group number as it appears on the insured's healthcare identification card.

Figure 19. FL 11a Not Required: Insured's Date of Birth, Sex

a. INSURED'S DATE OF BIRTH			SEX	
MM	DD	YY	M <input type="checkbox"/>	F <input type="checkbox"/>

Instructions: Leave this field blank.

Figure 20. FL 11b Situational: Other Claim ID

b. OTHER CLAIM ID (Designated by NUCC)
--

Instructions: When applicable, use to report appropriate Other Claim ID. Applicable Other Claim ID are designated by the NUCC under Code Set <https://www.nucc.org/>.

Figure 21. FL 11c Situational: Insurance Plan Name or Program Name

c. INSURANCE PLAN NAME OR PROGRAM NAME
--

Instructions: Enter the other insured's insurance plan or program name.

Figure 22. FL 11d Not Required: Is There Another Health Benefit Plan?

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>

Instructions: Leave this field blank.

Figure 23. FL 12 Situational: Patient Signature

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
SIGNED <i>Signature or "Signature on File"</i>	DATE <i>MM/DD/CCYY</i>

Instructions: Enter the member signature or signature on file with the date in MM/DD/CCYY format.

Figure 24. FL 13 Not Required: Insured's or Authorized Person's Signature

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

Instructions: Leave this field blank.

Figure 25. FL 14 Situational: Date of Current Illness, Injury, or Pregnancy

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			
MM	DD	YY	QUAL.

Instructions: For current illness, injury, or pregnancy, enter the date in the MM/DD/CCYY format.

Valid Values:

- 431 = Onset of current symptoms or illness
- 439 = Injury
- 484 = LMP

Figure 26. FL 15 Situational: Other Date

15. OTHER DATE			
QUA	MM	DD	YY

Instructions: Enter other date in the MM/DD/CCYY format. Applicable Qualifiers are designated by the NUCC under Code Set <https://www.nucc.org/>.

Figure 27. FL 16 Not Required: Date Patients Unable to Work in Current Occupation

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
FROM	MM	DD	YY	TO	MM	DD	YY

Instructions: Leave this field blank.

Figure 28. FL 17 Situational: Name of Referring Provider or Other Source

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
DN	Josephine Smith, M.D.

Instructions: Enter referring or ordering provider information, including the following:

- Provider Qualifier
 - Valid Values:
 - DN – Referring Provider
 - DK – Ordering Provider
 - DQ – Supervising Provider
- First and Last Name

Note: Lab, DME, and radiology claims require ordering physician to be entered.

Figure 29. FL 17a Required: Other ID Number

17a.	G2	001234856
------	----	-----------

Instructions: Enter the nine-digit Medicaid provider number of the ordering/referring provider and the appropriate qualifier.

Qualifier valid values are:

- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Medicaid ID
- LU – Location Number (Used for Supervising Provider only)
- ZZ – Taxonomy

Figure 30. FL 17b Required: Referring/Ordering NPI

17b.	NPI	999999999
------	-----	-----------

Instructions: Enter the ten-digit NPI number.

Figure 31. FL 18 Situational: Hospitalization Dates Related to Current Services

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
	MM		DD		YY		MM		DD		YY
FROM	01		03		20	TO	01		03		20

Instructions: Enter the date of hospital admission and discharge if the services billed are related to a hospitalization. If the patient has not been discharged, leave the discharge date blank.

Figure 32. FL 19 Situational: Additional Claim Information (Designated by NUCC)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Instructions: Use this field for when submitting a multi-page claim to indicate page count X of 9.

Figure 33. FL 20 Not Required: Outside Lab Charges

20. OUTSIDE LAB?	\$ CHARGES
<input type="checkbox"/> YES <input type="checkbox"/> NO	

Instructions: Leave this field blank.

Figure 34. FL 21 Required: Diagnosis or Nature of Illness or Injury

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	0		
A.	R06.00	B.	J18.9	C.	N39.0	D.	
E.		F.		G.		H.	
I.		J.		K.		L.	

Instructions: Enter the appropriate International Classification of Diseases (ICD) indicator for the date of service.

Note: The ICD indicator must be 0 (ICD-10-CM), 9 (ICD-9-CM), or blank. At least one Diagnosis code is required with eight characters or less.

Figure 35. FL 22 Situational: Resubmission Code (Original Reference No.)

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	2120364026258

Instructions: This form locator is used for submitting an adjustment or a void.

Resubmission Codes Valid Values are:

- 7 – Adjustment/Replacement
- 8 - Void

For the Original REF NO: Enter previous ICN or Transaction Control Number (TCN) assigned to the claim.

Additionally, please indicate “Adjustment” or “Void” in the blank space in the top right-hand corner of the claim form. Claim forms will be returned for missing resubmission codes. See [Figure 60](#).

Figure 36. FL 23 Situational: Prior Authorization Number

23. PRIOR AUTHORIZATION NUMBER
Q1234567

Instructions: Enter an authorization number without hyphens, dashes, spaces, etc. Enter only one authorization per one claim form. The leading letter must be included.

Services requiring prior authorization will deny if PA number is missing, incomplete, units billed exceeds the authorized units, etc.

Figure 37. FL 24a Required: Date of Service (lines 1-6)

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
01	03	20	01	03	20
01	03	20	01	03	20

Instructions: Enter the date for each procedure, service, or supply in MM/DD/YY format. When “From” and “To” dates are shown for a service of identical services, enter the number of days or units in [FL 24g \(Figure 43\)](#).

Figure 38. FL 24b Required: Place of Service

B. PLACE OF SERVICE
11
11

Instructions: Enter the appropriate two-digit code for the place of service code. The Place of Service Codes are available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Figure 39. FL 24c Situational: EMG

C. EMG

Instructions: Enter “Y” (Yes) or “N” (No) in the appropriate box.

Figure 40. FL 24d Required: Procedures, Services, or Supplies

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					
CPT/HCPCS	MODIFIER				
99251					
20600	25				

Instructions: Enter the following information:

- **Procedure Code** – Enter the appropriate Current Procedural Terminology (CPT)-4 / Healthcare Common Procedures Coding System (HCPCS) code that identifies the service provided.
- **Procedure Modifier** – Enter the appropriate procedure modifier that further qualifies the service provided. (Note: This field should only be used when applicable.)

Note: Some mental health providers are required to enter a specific modifier for each claim line. Fee schedules identifying modifier requirements are available at: [Fee Schedules and Rates](#).

Figure 41. FL 24e Required: Diagnosis Pointer

E. DIAGNOSIS POINTER
A
B

Instructions: Enter one diagnosis indicator (A, B, C, D, E, F, G, H) that identifies appropriate diagnosis for the procedures. These indicators should correspond to the line numbers of the diagnosis codes listed in [FL 21 \(Figure 34\)](#).

Figure 42. FL 24f Required: Charges (lines 1-6)

F. \$ CHARGES	
50	00
250	00

Instructions: Enter the charge for each listed service/procedure. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the right-hand area of the field if the amount is a whole number.

Figure 43. FL 24g Required: Days or Units Billed

G. DAYS OR UNITS
1
1

Instructions: Enter the number of days or units. This field is most used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Figure 44. FL 24h Situational: EPSDT/ Family Planning

H. EPSDT Family Plan

Instructions: When there is a requirement to report a Family Planning service, enter “F”. When there is a requirement to report this as a EPSDT service, enter “E”. When there is no requirement for Family Planning Services or EPSDT, leave the field blank.

Figure 45. FL 24i Required: ID Qualifier

I. ID. QUAL.
G2

Instructions: Enter the appropriate qualifier to identify if the number is a non-NPI.

Qualifier valid values are:

- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Medicaid ID
- LU – Location Number (Used for Supervising Provider only)
- ZZ – Taxonomy

Figure 46. FL 24j Required: Rendering Provider ID and NPI

J. RENDERING PROVIDER ID. #
282N0000X
8888888888

Instructions: Enter the rendering provider’s Taxonomy (ZZ) or related value to the qualifiers (0B, 1G, G2, and LU) in the shaded half of the claim line. Enter the ten-digit NPI in the bottom, (unshaded half of the claim line).

Figure 47. FL 25 Not Required: Federal Tax ID or SSN

25. FEDERAL TAX I.D. NUMBER	SSN EIN
	<input type="text"/> <input type="text"/>

Instructions: Leave this field blank.

Figure 48. FL 26 Situational: Patient Account Number

26. PATIENT'S ACCOUNT NO. 123548F

Instructions: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist the provider in patient identification.

Figure 49. FL 27 Not Required: Accept Assignment?

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
<input type="checkbox"/> YES <input type="checkbox"/> NO

Instructions: Leave this field blank.

Figure 50. FL 28 Required: Total Charge

28. TOTAL CHARGE
\$ 300 00

Instructions: Enter total charges for the services [i.e., total of all charges in [FL 24f \(Figure 42\)](#)].

Figure 51. FL 29 Situational: Amount Paid

29. AMOUNT PAID
\$ 125 00

Instructions: Enter total amount the member and/or other payers paid on the covered services only.

Figure 52. FL 30 Not Required: Reserved for NUCC Use

30. Rsvd for NUCC Use

Instructions: Leave this field blank.

Figure 53. FL 31 Required: Signature of Physician or Supplier and Date

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
<i>Add Signature Here</i>	MM/DD/CCYY
SIGNED	DATE

Instructions: Enter the signature of provider of service or supplier, or his/her representative, and the date in the MM/DD/CCYY format or alphanumeric date (e.g., January 01, 2022).

Figure 54. FL 32 Situational: Service Facility Location

32. SERVICE FACILITY LOCATION INFORMATION

ABC Hospital
123 Easy Street
Anytown, PA 19003

Instructions: Enter the service location where the services were rendered in the following format:

- Facility Name
- Street Address
- City, State Zip Code

Figure 55. FL 32a Situational: Service Facility NPI

a. 0123456789

Instructions: Enter the NPI of the servicing provider.

Figure 56. FL 32b Situational: Service Facility Other ID #

b. 282N0000X

Instructions: Enter the qualifier ZZ followed by the Taxonomy code if the NPI was used in FL 32a. Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

Figure 57. FL 33 Required: Billing Provider Info and Phone Number

33. BILLING PROVIDER INFO & PH # (215) 555-5555
ABC Medical Group
8 North American Street
Anytown, PA 19003

Instructions: Enter the billing provider name (last name, first name), address (including the expanded ZIP Code+4), and telephone number currently on file with DOM as the billing provider where services were rendered.

Figure 58. FL 33a Required: Billing Provider NPI

a. 2222222222

Instructions: Enter the NPI of the billing provider.

Atypical providers are required to enter the Medicaid provider ID on field 33b.

Figure 59. FL 33b Required: Billing Provider Other ID#

b. 282N0000X

Instructions: Enter the qualifier ZZ followed by the Taxonomy code if the NPI was used in FL 33a. Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the provider.

Figure 60. CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM										Adjustment or Void													
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE @NUCC 02/12																							
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)		6. INSURED'S ADDRESS (No., Street)													
7. PATIENT'S CITY		8. PATIENT'S STATE		9. PATIENT'S ZIP CODE		10. PATIENT'S TELEPHONE (Include Area Code)		11. INSURED'S CITY		12. INSURED'S STATE													
13. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		14. IS PATIENT'S CONDITION RELATED TO:		15. INSURED'S POLICY GROUP OR FECA NUMBER		16. INSURED'S DATE OF BIRTH MM DD YY		17. INSURED'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		18. OTHER CLAIM ID (Designated by NUCC)													
19. OTHER INSURED'S POLICY OR GROUP NUMBER		20. EMPLOYMENT? (Current or Previous)		21. INSURED'S DATE OF BIRTH MM DD YY		22. INSURED'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		23. OTHER CLAIM ID (Designated by NUCC)		24. INSURANCE PLAN NAME OR PROGRAM NAME													
25. RESERVED FOR NUCC USE		26. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. INSURED'S DATE OF BIRTH MM DD YY		28. INSURED'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		29. OTHER CLAIM ID (Designated by NUCC)		30. INSURANCE PLAN NAME OR PROGRAM NAME													
31. RESERVED FOR NUCC USE		32. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		33. CLAIM CODES (Designated by NUCC)		34. IS THERE ANOTHER HEALTH BENEFIT PLAN?		35. YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.		36. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)													
<p style="text-align: center;">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)</p> <p>SIGNED _____ DATE _____</p>																							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		19. \$ CHARGES													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		20. REGISTRATION CODE		21. ORIGINAL REF. NO.		22. PRIOR AUTHORIZATION NUMBER													
23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																							
24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read A-L to determine ICD-9-CM code)																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>A. _____</td> <td>B. _____</td> <td>C. _____</td> <td>D. _____</td> <td>E. _____</td> <td>F. _____</td> <td>G. _____</td> <td>H. _____</td> <td>I. _____</td> <td>J. _____</td> <td>K. _____</td> <td>L. _____</td> </tr> </table>												A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____
A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____												
25. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DAYS OF INJURY G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NN. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.																							
26. FEDERAL TAX I.D. NUMBER		27. PATIENT'S ACCOUNT NO.		28. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		29. TOTAL CHARGE		30. AMOUNT PAID		31. Read for NUCC Use													
32. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials. I certify that the statements on this reverse apply to this bill and are made a part thereof.)		33. SERVICE FACILITY LOCATION INFORMATION		34. BILLING PROVIDER INFO & PH #		35. NPI		36. NPI		37. NPI													
SIGNED _____ DATE _____		a. _____ b. _____		a. _____ b. _____		a. _____ b. _____		a. _____ b. _____		a. _____ b. _____													

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form

4.9. Filing Medicare Crossover Claims on the CMS-1500

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

MS Medicaid Crossover Cover Sheet – Effective October 1, 2025

Effective October 1, 2025, Mississippi Medicaid will require use of the MS Medicaid Crossover Cover Sheet for all crossover claims submitted via paper. Paper claims submitted without the new form and the Explanation of Medicare Benefits (EOMB), or completed incorrectly will be returned unprocessed.

Proper completion of this form allows Gainwell to accurately scan and key your paper claim with the correct claim type and filing indicators—ensuring faster and more accurate processing. The updated form and instructions are available under the “Provider Forms” section of DOM’s website: <https://medicaid.ms.gov/resources/forms/>.

Providers are required to submit a separate Medicare Crossover form for each payer that has processed the claim prior to Mississippi XIX (also known as a “primary payer”). Primary payers may be Medicare A, Medicare B, or Medicare C/ Advantage. Please refer to MS Medicare Crossover Sheet (Cover page) for instructions.

- In [FL 1 \(Figure 1\)](#), enter X in the box labeled “Medicare” when submitting a crossover claim and enter X in the box labeled “Medicaid” for non-crossover claims.
- Ensure that the beneficiary’s nine-digit Medicaid number is in [FL 1a \(Figure 2\)](#).
- Enter the NPI number of the billing provider who is the one to which Medicaid payment will be made in [FL 33 \(Figure 57\)](#). If FL 33 contains a group NPI provider number, enter the ten-digit NPI of the servicing/ rendering provider in [FL 24j \(Figure 46\)](#).
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB).
- Redact (cross out, etc.) all claim information from the EOMB that is not relevant to the claim and attach the EOMB to the back of the claim. Only attach the most recent EOMB that is relevant to the claim. Submitting multiple EOMB’s will delay claim processing or cause claim denials.
- The claim detail information should match the individual EOMB detail level information. Procedure and revenue codes must be an exact match.
- Enter the claim details in the order listed on the EOMB.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider must line out or redact patient data not applicable to the claim submitted. When multiple members are included on an EOMB, please redact members not applicable to claim being billed.
- The provider must line out or redact any claim line that has been previously paid by Medicaid, services the provider chooses not to bill Medicaid or that has been paid in full by Medicare or Medicare Part C Advantage Plan. EOMB must match details billed on the claim.
- Highlighting must not be used to indicate the information from the EOMB that applies to the claim.

- Cut/pasted EOMB's will result in claim denials.
- Screenshots of internal system payments are not acceptable EOMBs.

5. UB-04 Claim Form Version CMS-1450

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the UB-04 billing form and must be used in conjunction with the Mississippi Administrative Code Title 23. Institutional providers are strongly encouraged to bill electronic claims to reduce the potential for errors and speed reimbursement. The Administrative Code and fee schedules should be used as a reference for issues concerning policy and the specific procedures for which Medicaid reimburses. Contact Gainwell's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222 for questions and assistance.

5.1. Provider Types

The instructions for the UB-04 claim form are to assist the following types of providers:

- Dialysis Centers
- Home Health Agencies
- Hospice Providers
- Hospitals
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Nursing Facilities
- Psychiatric Residential Treatment Facilities (PRTF)
- Swing-Bed

5.2. Web Portal Reminder

Providers are encouraged to use the Mississippi MESA Web Portal for easy access to up-to-date information. The web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The web portal is available 24 hours a day, seven days a week, 365 days a year via the Internet at <https://portal.ms-medicaid-mesa.com/MS/Provider>.

5.3. Paper Claim Guidelines

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- An original UB-04 claim form must be completed.
- No photocopied or fax claims are accepted.
- Do not include handwritten information on the claim form.
- Blue or black ink must be used to fill out the form.
- The information on the form must be legible.
- No highlighters should be used.
- Correction fluid or correction tape should not be used.
- Names, codes, numbers, etc. must print in the designated fields for proper alignment.
- Claim information must remain within the outlines of the data fields.
- Claim information includes:
 - Beneficiary Medicaid ID
 - Provider NPI

- Diagnosis code
- Type of Bill
- At least one claim line detail
- Claim must include all required attachments when applicable. Attachments must be legible, and paid date must be included on the EOB/EOMB.

5.4. Multi-Page Paper Claims

When submitting UB-04 claims with multiple pages, the below guidelines should be followed:

- Multi-page claims are limited to ten pages with a maximum of 220 claim lines.
- The first form should not be totaled.
- Pages together must be clipped together.
- Indicate Page X of 10 in line 23.
- Use code 0001 (total charges) on the last page. Enter the 0001 totals code in the box next to the number 23 on the last page.
- If reporting a Third-Party Liability (TPL) payment, indicate in [FL 54 \(Figure 97\)](#) on the first page.
- Only one copy of an attachment (e.g., EOB, EOMB, and Consent Form) is required per claim.

5.5. Paper Claims with Attachments

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with third party payor source, all EOBs that relate to the claim should be included.
- MEDICARE DENIAL, SEE ATTACHED should be entered in FL 80 (Figure 124) for Medicare denials.
- TPL DENIAL, SEE ATTACHED should be entered in FL 80 for other insurance denials.
- Do not use red ink on attachments.

5.6. Electronic UB-04 Claims

Electronic UB-04 claims may be submitted to Mississippi Medicaid by:

- Using the Web Portal Claims Entry feature
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid
- Electronic UB-04 claims must be submitted in a format that is HIPAA compliant with the ANSI X12 837I claim standards.

5.7. Claim Mailing Address

Once the claim form has been completed and checked for accuracy, the completed claim form can be mailed to:

Mississippi Medicaid Program
PO Box 23076
Jackson, MS 39225-3076

5.8. UB-04 Claim Form Instructions – Institutional Claims

The field instructions are as follows:

Figure 61. FL 1 Required: Billing Provider Name, and Physical Address

Sunny Hospital
25 Elm St
Jackson, MS 39203-1555

Instructions: Enter the billing provider name and physical address (including the expanded ZIP Code+4) currently on file with DOM as follows:

***Note: P.O. Box Not Allowed**

- Line 1: Billing Provider Name
- Line 2: Billing Provider Street Address
- Line 3: Billing Provider City, State and Zip Code+4

Figure 62. FL 2 Situational: Service Location Information

Sunny Hospital
321 Sun Lane Drive
Jackson, MS 39201-0015

Instructions: This field is required when the billing provider has multiple Medicaid Provider ID numbers associated with the NPI. Enter the service location name and address (including the expanded ZIP Code+4) where the patient was seen (which must match the service location address currently on file with DOM for the billing provider where the service was rendered) as follows:

- Line 1: Billing Provider Name
- Line 2: Billing Provider Street Address
- Line 3: Billing Provider City, State and Zip Code+4

Figure 63. FL 3a Situational: Patient Control Number

3a PAT. CNTL #	987562
---------------------------	---------------

Instructions: Enter the patient's unique account number assigned by the provider account number. Patient Control number must be 20 characters or less.

Figure 64. FL 3b Situational: Medical/Health Record Number

b. MED. REC. #	HX1590Z1
---------------------------	-----------------

Instructions: Enter the number assigned to the patient's medical/health record by the provider. This is not the same information as FL 3a. Patient Medical/Health Record number must be 38 characters or less.

Figure 65. FL 4 Required: Type of Bill

4	TYPE OF BILL
XXX	

Instructions: Enter the appropriate Type of Bill (TOB) code. This code indicates the specific TOB being submitted and is critical to ensure accurate payment. This four-digit code requires a leading zero plus one digit from each of the four categories, written in the following sequence:

- First digit – Type of Facility
- Second digit – Bill Classification
- Third digit – Frequency

Example: TOB 111

- First digit – 1-Hospital
- Second digit – 1-Inpatient (Including Medicare Part A)
- Third digit – 1-Admit Through Discharge

The valid values for the first, second, and third digits are listed in the tables below.

Table 3. Type of Facility (First Digit) Code Values

Type of Facility (First Digit)	Code
Hospital	1
Skilled Nursing	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Specialty Facility	8
RESERVED for NATIONAL USE	9

Table 4. Bill Classification – Except Clinics and Special Facilities (Second Digit) Code Values

Bill Classification – Except Clinics and Special Facilities (Second Digit)	Code
Inpatient (Including Medicare Part A)	1
Inpatient (Medicare Part B Only)	2
Outpatient	3
Other (for Hospital Referenced Diagnostic Services, or Home Health Not Under Plan of Treatment)	4
Intermediate Care - Level I	5
Intermediate Care - Level II	6
Subacute Inpatient (Revenue Code 19X Required)	7
Swing Beds	8
RESERVED for NATIONAL USE	9

Table 5. Bill Classification – Clinics Only (Second Digit) Code Values

Bill Classification – Clinics Only (Second Digit)	Code
Rural Health	1
Hospital Based or Independent Renal Dialysis Center	2
Free Standing	3
Outpatient Rehabilitation Facility (ORF)	4
Comprehensive Outpatient Rehabilitation Facilities (CORFS)	5
Community Mental Health Center	6
RESERVED for NATIONAL USE	7-8
Other	9

Table 6. Bill Classification – Special Facilities Only (Second Digit) Code Values

Bill Classification – Special Facilities Only (Second Digit)	Code
Hospice (Non-Hospital Based)	1
Hospice (Hospital Based)	2
Ambulatory Surgery Center	3
Free Standing Birthing Center	4
Rural Primary Care Hospital	5
RESERVED for NATIONAL USE	6-8
Other	9

Table 7. Frequency (Third Digit) Code Values

Frequency (Third Digit)	Code
Non-Payment/Zero Claim	0
Admit Through Discharge	1
Interim, First Claim	2
Interim, Continuing Claim	3
Interim, Last Claim	4
Late Charge(s) Only Claim	5
Replacement of Prior Claim	7
Void/Cancel of Prior Claim	8
RESERVED for NATIONAL USE	9

Figure 66. FL 5 Situational: Federal Tax Number

5 FED. TAX NO.
64-XXXXXXX

Instructions: This is the Tax Identification Number (TIN) of the entity to be paid for the submitted services.

Figure 67. FL 6 Required: Statement Covers Period (From – Through)

6	STATEMENT COVERS PERIOD
FROM	THROUGH
01012022	01052022

Instructions: The date format is eight digits MMDDCCYY (e.g., 01012022). Enter the beginning service date in the "From" area and the end service date in the "Through" area of this field. For services received on a single day, enter that date on both the "From" and "Through" box.

Figure 68. FL 7 Not Required: Reserved for Assignment by the NUBC

7

Instructions: Leave this field blank.

Figure 69. FL 8a-b: Patient Name

8 PATIENT NAME	a	
b	Smile, Joe L	

Instructions: Enter the patient's full name as follows:

- FL 8a: Patient's Identifier – Leave this field blank.
- FL 8b: Patient's Name – This is a required field. Enter the patient's name as it appears on the Medicaid ID card in the last name, first name, and middle initial format.

Figure 70. Examples of Patient's Medicaid ID Card



Figure 71. FL 9a-e Situational: Patient Address

9 PATIENT ADDRESS	a	402 Concourse Lane					
b	Meridian	c	MS	d	39207	e	

Instructions: Enter the patient's full mailing address as follows:

- FL 9a: Patient's Street Address – Enter the patient's street address or PO Box.
- FL 9b: Patient's City – Enter the patient's city.
- FL 9c: Patient's State – Enter the patient's state.
- FL 9d: Patient's ZIP Code – Enter the patient's zip code.
- FL 9e: Patient's Country Code – Enter the patient's country code, which is only required if the country is other than USA.

Figure 72. FL 10 Required: Patient Birth Date

10 BIRTHDATE
03201971

Instructions: Enter the month, day, and year of birth of patient. The date format is eight digits [MMDDCCYY (e.g., 03201971)].

Figure 73. FL 11 Required: Patient Sex

11 SEX
M

Instructions: Enter the sex of the patient. The valid values are:

- F – Female
- M – Male
- U – Unknown

Figure 74. FL 12-15 Situational: Admission Date, Hour, Type, and Source

ADMISSION			
12 DATE	13 HR	14 TYPE	15 SRC
01022022	1800	1	2

Instructions: Enter the admission date, hour, type, and source as follows:

- FL 12: Admission Date – Enter the month, day, and year of the admission of the member.
 - The date format is eight digits [MMDDCCYY (e.g., 01012022)].
 - This field is required on inpatient claims.
- FL 13: Admission Hour – Enter the time of admission in military time (e.g., 06:00 p.m. is 18:00 in military time). This field is required on inpatient claims.
- FL 14: Admission Type – Enter the appropriate admission code. This field is required when patient is being admitted for inpatient services.
 - Valid values are:
 - 1 – Emergency
 - The patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling conditions.
 - 2 – Urgent
 - The patient requires immediate attention for the care and treatment of a physical or mental disorder.
 - 3 – Elective
 - The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
 - 4 – Newborn
 - Any newborn infant born within a hospital setting.
 - 5 – Trauma Center
 - The patient visits a trauma center/hospital (as licensed or designated by the state or local government entity authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation).
 - 9 – Information Unavailable
 - The provider is unable to clarify the type of admission; this is rarely used.

- FL 15: Admission Source – Enter the code indicating the source of the referral for the admission or visit. Required for all inpatient and outpatient services.

Table 8. Admission Source Code Definitions

Code	Newborn Admission Sources/Definition
1-3	Discontinued
4	Born inside hospital
5	Born outside hospital
Code	Admission Sources/Definition
1	Non-healthcare Facility Point of Origin
2*	Clinic Referral
3	Discontinued
4*	Transfer from a Hospital (different facility)
5	Transfer from a Skilled Nursing Facility
6*	Transfer from another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	Reserved for Assignment by NUBC
B	Transfer from another home health agency
C	Readmission to same home health agency
D	Transfer from one distinct unit of hospital to another distinct unit of hospital
E*	Transfer from Ambulatory Surgical Center
F*	Transfer from Hospice

* Requires NPI in FL 76

Figure 75. FL 16 Not Required: Discharge Hour

16 DHR

Instructions: Leave this field blank.

Figure 76. FL 17 Required: Patient Discharge Status

17 STAT
01

Instructions: Enter the member's disposition or discharge status at the end of service for the period covered on this bill, as reported in [FL 6, \(Figure 67\)](#). The valid values and their descriptions for this field are listed in the following table.

Table 9. Patient Discharge Status and Description

Patient Status	Description
01	DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE)
02	DISCHARGED/TRANSFERRED TO A SHORT-TERM GENERAL HOSPITAL FOR INPATIENT CARE
03	DISCHARGED/TRANSFERRED TO SNF WITH MEDICARE CERTIFICATION IN ANTICIPATION OF COVERED SKILLED CARE
04	DISCHARGED/TRANSFERRED TO AN INTERMEDIATE CARE FACILITY (ICF)

Patient Status	Description
05	DISCHARGED/TRANSFERRED TO A DESIGNATED CANCER CENTER OR CHILDRENS HOSPITAL
06	DISCHARGED/TRANSFERRED HOME UNDER CARE OF ORGANIZED HH SVC ORG IN ANTICIPATION OF COVD SKILLED CARE
07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE
08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF HOME IV PROVIDER
09	ADMITTED AS AN INPATIENT TO THIS HOSPITAL
20	EXPIRED
21	DISCH/TRANSF TO COURT/LAW ENFORCEMENT
30	STILL PATIENT
40	EXPIRED AT HOME
41	EXPIRED IN A MEDICAL FACILITY (E.G. HOSPITAL, SNF, ICF, OR FREE-STANDING HOSPICE)
42	EXPIRED - PLACE UNKNOWN
43	DISCHARGED/TRANSFERRED TO A FEDERAL HEALTH CARE FACILITY
50	HOSPICE - HOME
51	HOSPICE - MEDICAL FACILITY
61	DISCHARGED/TRANSFERRED TO HOSPITAL-BASED MEDICARE APPROVED SWING BED
62	DISCHARGED/TRANSFERRED TO IP REHAB FACILITY (IRF) INCLUDING REHAB DISTINCT PART UNITS OF A HOSPITAL
63	DISCHARGED/TRANSFERRED TO A MEDICARE CERTIFIED LONG TERM CARE HOSPITAL (LTCH)
64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT UNDER MEDICARE
65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART UNIT OF A HOSPITAL
66	DISCHARGED/TRANSFERRED TO A CRITICAL ACCESS HOSPITAL (CAH)
69	DISCH/TRANSF TO A DESIGNATED DISASTER ALTERNATIVE CARE SITE
70	DISCH/TRANSF TO ANOTHER TYPE OF INSTITUTION NOT DEFINED ELSEWHERE IN THIS CODE LIST

Figure 77. FL 18-28 Situational: Condition Codes

CONDITION CODES										
18	19	20	21	22	23	24	25	26	27	28
02	40									

Instructions: Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. This field is required when there is a Condition Code that applies to this claim.

Figure 78. FL 29 Not Required: Accident State

29 ACDT STATE

Instructions: Leave this field blank.

Figure 79. FL 30 Not Required: Reserved

30

Instructions: Leave this field blank.

Figure 80. FL 31-34 Situational: Occurrence Codes/Date

31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE
24	01152022						

Instructions: Enter the Occurrence code and date. The date format is eight digits [MMDDCCYY (e.g., 01012022)]. This field is required when there is a significant occurrence (event) relating to this claim. Event codes should be submitted in alphanumeric sequence.

Figure 81. FL 35-36 Situational: Occurrence Span Codes From and Through Dates

35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH
74	01022022	01052022			

Instructions: Enter the Occurrence Span Code from and through dates. This field is required when there is a significant occurrence (event) relating to this claim. Event codes are two alphanumeric digits; dates are shown numerically as MMDDCCYY through MMDDCCYY.

Figure 82. FL 37 Not Required: Reserved

37

Instructions: Leave this field blank.

Figure 83. FL 38 Situational: Responsible Party Name and Address

38
MEDICARE ADVANTAGE

Instructions: Enter “Medicare A”, “Medicare B”, or “Medicare Advantage” in this field if the member has Medicare or Medicare Advantage when billing a Medicare crossover claim.

Figure 84. FL 39-41 Situational: Value Codes and Amounts

Correct:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	66	1000 00	80	15	81	5
b	82	25				
c						
d						

Incorrect:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	80	25	A1	992 00	66	500 00
b	A2	6200 00	82	25 00	81	0
c						
d						

Value Codes are NOT in numerical order.

This represents 2500 days, NOT 25!

Do not list Value Codes if zero.

Instructions: Value codes must be entered in numeric sequence, starting in Form Locators 39a through 41a, 39b through 41b, 39c through 41c, and lastly, 39d through 41d.

Please note that when entering days, place the number to the far right of the Value Code Amount (in the cents field). For example, 1 – 9 days would be entered in the same position you would enter 1 – 9 cents. Days 10 – 99 would be entered in the same positions you would enter ten to ninety-nine cents. Days 100 – 999 would be entered in the same positions you would enter one dollar to nine dollars and ninety-nine cents.

Figure 85. FL 42 Required: Revenue Code

42 REV. CD.
0110
0250
0450

Instructions: Enter the revenue code that identifies a specific service or item. The specific revenue codes can be taken from the revenue code section of the Uniform Billing Manual. Codes are also available from the National Uniform Billing Committee (NUBC) (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Note: 0001 is not a valid Revenue Code and should not be used.

Figure 86. FL 43 Required: Revenue Code Description

43 DESCRIPTION
Room and Board-Private
Pharmacy - General
Emergency Room - General

Instructions: Enter the standard abbreviated description of the related revenue code categories included on this bill. (See FL 42 for description of each revenue code category.) FL 43 is also

used to report the NDC. The NDC must begin with 'N4' followed by the 11-digit NDC and the Unit Measure Qualifier. Unit Measure Qualifiers are:

F2 – International Unit

GR – Gram

ME – Milligram

ML – Milliliter

UN – Unit

Example N400023114501UN

Figure 87. FL 44 Situational: HCPCS/Rate/HIPPS Code

44 HCPCS / RATE / HIPPS CODE

Instructions: Enter the following when applicable:

1. The HCPCS codes applicable to the ancillary service and outpatient bills
2. The accommodation rate for inpatient bills
3. The Health Insurance Prospective Payment System (HIPPS) rate codes that represent specific set of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems

Figure 88. FL 45 Required: Service Date

45 SERV. DATE
01012022
01012022
01012022

Instructions: Enter the month, day, and year the member service was provided. The date format is eight digits [MMDDCCYY (e.g., 01012022)].

Figure 89. FL 46 Required: Service Units

46 SERV. UNITS
4
500
1

Instructions: Enter the quantitative measure of services rendered for each procedure or revenue code for the total number of covered accommodation days, ancillary units of service, or visits, where appropriate. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

Figure 90. FL 47 Situational: Total Charges

47 TOTAL CHARGES	
4744	00
1742	79
800	00

Instructions: Enter the total charges for the related revenue or procedure code for the current billing period as entered in [FL 6 \(Figure 67\)](#) of the statement covers period.

Figure 91. FL 48 Not Required: Non-Covered Charges

48 NON-COVERED CHARGES

Instructions: Leave this field blank.

Figure 92. FL 49 Not Required: Reserved for Assignment by the NUBC

49

Instructions: Leave this field blank.

Figure 93. FL 50 Required: Payer Name

50 PAYER NAME	
A	Primary Insurance Group
B	Medicaid
C	

Instructions: As applicable, enter the name of the member's primary, secondary, and tertiary insurance on Lines A, B and C, respectively and to always include Medicaid. "Medicaid" information is entered on line A, if the claim is submitted with no TPL.

Figure 94. FL 51 Situational: Payer ID

51 HEALTH PLAN ID

Instructions: Enter the number used to identify the payer. This field is required. If other payers are involved in potentially paying the claim, enter the ID number used to identify the payer.

If other insurance is involved in the payment of the claim, the EOB from the other insurance must be included with the submission of the claim.

Figure 95. FL 52 Situational: Claim Filing Indicator Code

52 REL. INFO

Instructions: Enter the appropriate claim filing indicator code. Required for Medicare Advantage Part C/Medicare Part A and Part B claims.

Note: Use a value of 'MA' or 'MB' to identify Medicare Payers, or use '16' to identify Medicare C Advantages Plan. For any Commercial Insurance payer, use a value of "CI" to identify TPL Payer.

Figure 96. FL 53 Situational: Assignment of Benefits

53 ASG. BEN.

Instructions: Enter the assignment of benefits. Valid values are "N" for No and "Y" for Yes.

Figure 97. FL 54 Situational: Prior Payments

54 PRIOR PAYMENTS
5500 : 00

Instructions: Enter payment(s) received from any other insurance carriers for claim services.

Figure 98. FL 55 Situational: Estimated Amount Due

55 EST. AMOUNT DUE
1100 : 00

Instructions: Enter the amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

Figure 99. FL 56 Required: NPI – Billing Provider

56 NPI	9874561230
--------	------------

Instructions: Enter the unique identification number assigned to the provider submitting the bill. This is a 10-digit number that will be used to identify you to your health care partners including all payers.

Figure 100. FL 57 Situational: Other (Billing) Provider Identifier

57	
OTHER	
PRV ID	

Instructions: Enter the other (billing) provider identifier. Identifiers can be: 0B,1B,1G, G2, LU. This field may be used to report other provider identifiers as assigned by the health plan [as indicated in [FL 50 Lines A-C \(Figure 93\)](#)]. Use the qualifiers (0B,1B,1G, G2, and LU) to identify the other providers. (Example: G2 Provider Medicaid ID – 123456789 = G2123456789.)

Figure 101. FL 58 Required: Insured's Name

	58 INSURED'S NAME
A	Smile, Joe L
B	Smile, Joe L
C	

Instructions: Enter the name of the individual under whose name the insurance benefit is carried. Enter the policyholder's last name, first name, and middle initial. Entering incorrect information will result in claim denial(s).

Figure 102. FL 59 Not Required: Patient Relationship to Insured

59 P.REL

Instructions: Leave this field blank.

Figure 103. FL 60 Required: Insured's Unique Identifier

60 INSURED'S UNIQUE ID
8764531A
333666999

Instructions: Enter the unique number assigned by the health plan to the insured if there is another health plan, as well as entering the Members Medicaid ID.

Figure 104. FL 61 Situational: Insured's Group Name

61 GROUP NAME
National Health Care Plus

Instructions: Enter the group name or plan providing the member's primary, secondary, and tertiary insurance on lines A, B, and C according to proper billing order, exactly as it appears on the health insurance card. Do not enter a group name on the line that shows payor, "Medicaid". This field is required when there is third party coverage.

Figure 105. FL 62 Situational: Insured's Group Number

62 INSURANCE GROUP NO.	
45-1690	A
	B
	C

Instructions: Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered. Enter the member's primary, secondary, and tertiary insurance on Lines A, B and C, according to proper billing order.

Figure 106. FL 63 Situational: Treatment Authorization Codes

63 TREATMENT AUTHORIZATION CODES	
A	
B	A500001
C	

Instructions: Enter the authorization number in this field. Only one authorization number may be entered per claim. This field is required when an authorization code assigned by the Utilization Management Organization is required to be reported on the claim.

Figure 107. FL 64 Situational: Document Control Number (Used for Submitting Adjustments/Voids)

64 DOCUMENT CONTROL NUMBER
22210290000002

Instructions: Enter the original claim ICN that is being requested to be replaced/adjusted or voided. This field is required when the TOB Frequency [\[FL 4 \(Figure 65\)\]](#) indicates this claim is a replacement/adjusted (7) or void (8) to a previously adjudicated claim. Additionally, please indicate "Adjustment" or "Void" in FL 80 of the claim form. See [Figure 126](#).

Figure 108. FL 65 Not Required: Employer Name

65 EMPLOYER NAME	
	A
	B
	C

Instructions: Leave this field blank.

Figure 109. FL 66 Required: Diagnosis and Procedure Code Qualifier (ICD Revision Indicator)

66 DX
0

Instructions: Enter the qualifier that denotes the revision of International Classification of Diseases (ICD) reported. Qualifier code "9" [ICD Ninth Revision (ICD-9-CM)] or "0" [ICD Tenth Revision (ICD-10-CM/ICD-9-PCS)] is required.

Figure 110. FL 67 Required: Principal Diagnosis Code (DX) and Present on Admission (POA) Indicator

E871	Y
------	---

Instructions: Enter the ICD diagnosis code, appropriate to the ICD revision indicated in [FL 66 \(Figure 109\)](#) describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The DX is required; the POA is situational but required for Inpatient claims.

Figure 111. FL 67(a – q) Situational: Other DX and POA Indicator

M810	Y	M4850XA	Y
------	---	---------	---

Figure 112. FL 68 Not Required: Reserved for Assignment by the NUBC

68

Instructions: Leave this field blank.

Figure 113. FL 69 Situational: Admitting Diagnosis Code

69 ADMIT DX	E871
----------------	------

Instructions: Enter the ICD diagnosis code, appropriate to the ICD revision indicated in [FL 66 \(Figure 109\)](#), describing the patient's diagnosis at the time of admission. This field is required when claim involves an inpatient admission.

Figure 114. FL 70 Situational: Patient's Reason for Visit

70 PATIENT REASON DX	a	b	c
-------------------------	---	---	---

Instructions: Enter the ICD diagnosis codes, appropriate to the ICD revision indicated in [FL 66 \(Figure 109\)](#), describing the patient's stated reason for visit.

Figure 115. FL 71 Not Required: Prospective Payment System (PPS) Code

71 PPS CODE	
----------------	--

Instructions: Leave this field blank.

Figure 116. FL 72a–c Situational: External Cause of Injury (ECI) Code and POA Indicator

72 ECI	V8604XA	Y	b	c
-----------	---------	---	---	---

Instructions: Enter the ICD diagnosis codes, appropriate to the ICD revision indicated in [FL 66 \(Figure 109\)](#), pertaining to the environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.

Figure 117. FL 73 Not Required: Reserved for Assignment by the NUBC

73

Instructions: Leave this field blank.

Figure 118. FL 74 Situational: Principal Procedure Code and Date

74	PRINCIPAL PROCEDURE CODE	DATE
	009A0ZZ	01022022

Instructions: Enter the ICD procedure code appropriate to the ICD revision indicated in [FL 66 \(Figure 109\)](#), that identifies the inpatient principal procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. This field is required on inpatient claims when a procedure was performed. The date format is eight digits MMDDCCYY (e.g., 01012022). If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

Figure 119. FL 74a-e Situational: Other Procedure Codes and Dates

a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE	
009B3ZX	01022022		

c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE	

Instructions: Enter the other procedure codes and dates. This field is required on inpatient claims when additional procedures must be reported. The date format is eight digits [MMDDCCYY (e.g., 01012022)]. The ICD procedure codes appropriate to the ICD revision indicated in [FL 66 \(Figure 109\)](#), that identify all significant procedures, other than the principal procedure, and the dates (identified by code) on which the procedures were performed.

Figure 120. FL 75 Not Required: Reserved for Assignment by the NUBC

75

Instructions: Leave this field blank.

Figure 121. FL 76 Situational: Attending Provider Name and Identifiers

76 ATTENDING	NPI 3575986110	QUAL		207Q00000X
LAST Murdoch		FIRST Sam		

Instructions: Enter the attending provider's NPI, Qualifier (ZZ)/Taxonomy, Last Name, and First Name. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Figure 122. FL 77 Situational: Operating Physician Name and Identifiers

77 OPERATING	NPI	QUAL	
LAST		FIRST	

Instructions: Enter the name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Figure 123. FL 78–79 Situational: Other Provider (Individual) Names and Identifiers

78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

Instructions: Enter the identification number and name of the other physician if applicable.

Figure 124. FL 80 Situational: Remarks

80 REMARKS
Adjustment or Void

Instructions: Enter "Adjustment" or "Void" here.

Figure 125. FL 81cc Required: Code-Code Field

81CC a	B3	282N00000X	
b			
c			
d			

Instructions: Enter the "B3" Qualifier followed by the billing provider taxonomy. This is a required field to report billing provider taxonomy.

Figure 126. UB-Claim Form

1		2		3a PAT CONT # 3b MED REC #		4 TYPE OF BILL	
5 PATIENT NAME		6 PATIENT ADDRESS		7		8 STATEMENT COVERED PERIOD FROM TO/THROUGH	
9	10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION 13-14 15 TYPE 15 SINC	16 CHARGE	17 STATE	18
19	20	21	22	23	24	25	26
27	28	29	30	31	32	33	34
35	36	37	38	39	40	41	42
43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58
59	60	61	62	63	64	65	66
67	68	69	70	71	72	73	74
75	76	77	78	79	80	81	82
83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98
99	100	101	102	103	104	105	106
107	108	109	110	111	112	113	114
115	116	117	118	119	120	121	122
123	124	125	126	127	128	129	130
131	132	133	134	135	136	137	138
139	140	141	142	143	144	145	146
147	148	149	150	151	152	153	154
155	156	157	158	159	160	161	162
163	164	165	166	167	168	169	170
171	172	173	174	175	176	177	178
179	180	181	182	183	184	185	186
187	188	189	190	191	192	193	194
195	196	197	198	199	200	201	202
203	204	205	206	207	208	209	210
211	212	213	214	215	216	217	218
219	220	221	222	223	224	225	226
227	228	229	230	231	232	233	234
235	236	237	238	239	240	241	242
243	244	245	246	247	248	249	250
251	252	253	254	255	256	257	258
259	260	261	262	263	264	265	266
267	268	269	270	271	272	273	274
275	276	277	278	279	280	281	282
283	284	285	286	287	288	289	290
291	292	293	294	295	296	297	298
299	300	301	302	303	304	305	306
307	308	309	310	311	312	313	314
315	316	317	318	319	320	321	322
323	324	325	326	327	328	329	330
331	332	333	334	335	336	337	338
339	340	341	342	343	344	345	346
347	348	349	350	351	352	353	354
355	356	357	358	359	360	361	362
363	364	365	366	367	368	369	370
371	372	373	374	375	376	377	378
379	380	381	382	383	384	385	386
387	388	389	390	391	392	393	394
395	396	397	398	399	400	401	402
403	404	405	406	407	408	409	410
411	412	413	414	415	416	417	418
419	420	421	422	423	424	425	426
427	428	429	430	431	432	433	434
435	436	437	438	439	440	441	442
443	444	445	446	447	448	449	450
451	452	453	454	455	456	457	458
459	460	461	462	463	464	465	466
467	468	469	470	471	472	473	474
475	476	477	478	479	480	481	482
483	484	485	486	487	488	489	490
491	492	493	494	495	496	497	498
499	500	501	502	503	504	505	506
507	508	509	510	511	512	513	514
515	516	517	518	519	520	521	522
523	524	525	526	527	528	529	530
531	532	533	534	535	536	537	538
539	540	541	542	543	544	545	546
547	548	549	550	551	552	553	554
555	556	557	558	559	560	561	562
563	564	565	566	567	568	569	570
571	572	573	574	575	576	577	578
579	580	581	582	583	584	585	586
587	588	589	590	591	592	593	594
595	596	597	598	599	600	601	602
603	604	605	606	607	608	609	610
611	612	613	614	615	616	617	618
619	620	621	622	623	624	625	626
627	628	629	630	631	632	633	634
635	636	637	638	639	640	641	642
643	644	645	646	647	648	649	650
651	652	653	654	655	656	657	658
659	660	661	662	663	664	665	666
667	668	669	670	671	672	673	674
675	676	677	678	679	680	681	682
683	684	685	686	687	688	689	690
691	692	693	694	695	696	697	698
699	700	701	702	703	704	705	706
707	708	709	710	711	712	713	714
715	716	717	718	719	720	721	722
723	724	725	726	727	728	729	730
731	732	733	734	735	736	737	738
739	740	741	742	743	744	745	746
747	748	749	750	751	752	753	754
755	756	757	758	759	760	761	762
763	764	765	766	767	768	769	770
771	772	773	774	775	776	777	778
779	780	781	782	783	784	785	786
787	788	789	790	791	792	793	794
795	796	797	798	799	800	801	802
803	804	805	806	807	808	809	810
811	812	813	814	815	816	817	818
819	820	821	822	823	824	825	826
827	828	829	830	831	832	833	834
835	836	837	838	839	840	841	842
843	844	845	846	847	848	849	850
851	852	853	854	855	856	857	858
859	860	861	862	863	864	865	866
867	868	869	870	871	872	873	874
875	876	877	878	879	880	881	882
883	884	885	886	887	888	889	890
891	892	893	894	895	896	897	898
899	900	901	902	903	904	905	906
907	908	909	910	911	912	913	914
915	916	917	918	919	920	921	922
923	924	925	926	927	928	929	930
931	932	933	934	935	936	937	938
939	940	941	942	943	944	945	946
947	948	949	950	951	952	953	954
955	956	957	958	959	960	961	962
963	964	965	966	967	968	969	970
971	972	973	974	975	976	977	978
979	980	981	982	983	984	985	986
987	988	989	990	991	992	993	994
995	996	997	998	999	1000	1001	1002
1003	1004	1005	1006	1007	1008	1009	1010
1011	1012	1013	1014	1015	1016	1017	1018
1019	1020	1021	1022	1023	1024	1025	1026
1027	1028	1029	1030	1031	1032	1033	1034
1035	1036	1037	1038	1039	1040	1041	1042
1043	1044	1045	1046	1047	1048	1049	1050
1051	1052	1053	1054	1055	1056	1057	1058
1059	1060	1061	1062	1063	1064	1065	1066
1067	1068	1069	1070	1071	1072	1073	1074
1075	1076	1077	1078	1079	1080	1081	1082
1083	1084	1085	1086	1087	1088	1089	1090
1091	1092	1093	1094	1095	1096	1097	1098
1099	1100	1101	1102	1103	1104	1105	1106
1107	1108	1109	1110	1111	1112	1113	1114
1115	1116	1117	1118	1119	1120	1121	1122
1123	1124	1125	1126	1127	1128	1129	1130
1131	1132	1133	1134	1135	1136	1137	1138
1139	1140	1141	1142	1143	1144	1145	1146
1147	1148	1149	1150	1151	1152	1153	1154
1155	1156	1157	1158	1159	1160	1161	1162
1163	1164	1165	1166	1167	1168	1169	1170
1171	1172	1173	1174	1175	1176	1177	1178
1179	1180	1181	1182	1183	1184	1185	1186
1187	1188	1189	1190	1191	1192	1193	1194
1195	1196	1197	1198	1199	1200</		

5.9. Filing Medicare Crossover Claims on the UB-04

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

Effective October 1, 2025, Mississippi Medicaid will require use of the MS Medicaid Crossover Cover Sheet for all crossover claims submitted via paper. Paper claims submitted without the new form and the Explanation of Medicare Benefits (EOMB) or completed incorrectly will be returned unprocessed.

Proper completion of this form allows Gainwell to accurately scan and key your paper claim with the correct claim type and filing indicators—ensuring faster and more accurate processing. The updated form and instructions are available under the “Provider Forms” section of DOM’s website: <https://medicaid.ms.gov/resources/forms/>.

Providers are required to submit a separate Medicare Crossover form for each payer that has processed the claim prior to Mississippi XIX (also known as a “primary payer”). Primary payers may be Medicare A, Medicare B, or Medicare C/ Advantage. Please refer to MS Medicare Crossover Sheet (Cover page) for instructions.

- The beneficiary’s Medicare number should be entered in [FL 60 \(Figure 103\)](#).
- The beneficiary’s nine-digit Medicaid number should be entered in [FL 60 \(Figure 93\)](#).
- The ten-digit NPI number should be entered in [FL 56 \(Figure 99\)](#).
- Optional: The nine-digit Medicaid provider number should be entered in [FL 57 \(Figure 100\)](#).
- Required: Filing Indicator FL 52
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Redact all claim information from the EOMB that is not relevant to the claim and attach the EOMB to the back of the claim.
- For outpatient crossover claims, the claim detail information should match the individual EOMB detail level information.
- Enter the claim details in the order listed on the EOMB.
- For inpatient crossover claims, the total dollar amounts/payment must be provided on the attached EOMB.
- Inpatient crossover claims only require header amounts be entered.
- Any prior payer payments should be reported in [FL 54 \(Figure 97\)](#) of the UB-04.

The Medicare EOMB must be completely legible and copied in its entirety. Illegible EOMBs will be returned or result in claim denial(s). The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider must line out or redact patient data not applicable to the claim submitted.
- The provider must line out or redact any claim line that has been previously paid by Medicaid, services the provider chooses not to bill Medicaid, or services that have been paid in full by Medicare or Medicare Part C Advantage Plan.
- Handwritten HCPCS/NDCs are allowed when indicated.
- Highlighting must not be used to indicate the information from the EOMB that applies to the claim.

6. Dental Claim Form Instructions (Version 2012 American Dental Association)

This section explains the procedures for obtaining reimbursement for dental services submitted to Medicaid on the 2012 American Dental Association (ADA) claim form. Mississippi Medicaid accepts both electronic and paper dental claims. Dental providers are strongly encouraged to bill electronic claims to reduce the potential for errors and speed reimbursement. This section only addresses billing procedures and must be used in conjunction with the Administrative Code Title 23 Part 204. The Dental Fee Schedule is available on the Medicaid website at <http://www.medicaid.ms.gov> or on the Web Portal at <https://portal.ms-medicaid-mesa.com/MS/Provider>. For questions, contact Gainwell's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222.

6.1. Provider Types

The instructions for the 2012 ADA claim form are to assist the following providers:

- Dentists
- Federally Qualified Health Center (FQHC) dentists
- Rural Health Clinic (RHC) dentists

6.2. Electronic Dental Claims

Electronic dental claims may be submitted to Mississippi Medicaid by:

- Using the Web Portal Claims Entry feature
- Using other proprietary software purchased by the dental provider

Electronic dental claims must be submitted in a format that is HIPAA compliant with the ANSI X12 837D claim standards.

6.3. Paper Dental Claims Guidelines

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- An original 2012 ADA claim form must be completed.
- No photocopied or fax claims are accepted.
- Do not include handwritten information on the claim form.
- Blue or black ink must be used to fill out the form.
- The information on the form must be legible.
- No highlighters should be used.
- Correction fluid or correction tape should not be used.
- Names, codes, numbers, etc. must print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable. Claims will be returned for no signature.

6.4. Multi-Page Paper Claims

When submitting American Dental Association (ADA) Dental claims form with multiple pages, the below guidelines should be followed:

- Multi-page claims are limited to five pages with a maximum of 50 claim lines.
- If the number of procedures reported exceeds the number of lines available on one claim (ten lines per claim), the remaining procedures must be listed on a separate, fully completed claim form.
- The first form should not be totaled.
- Multiple pages should be clipped together.
- Indicate Page X of 5 in the white space at the bottom of the claim form.
- [FL 31 \(Figure 139\)](#) should be used to indicate a TPL payment on last page, if applicable.
- Only one copy of an attachment (e.g., EOB, EOMB, Consent Form) is required.

6.5. Dental Paper Claims with Attachments

When submitting attachments with the ADA Dental claim form, the below guidelines should be followed:

- Attachments must be clipped to the claim.
- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- Do not use red ink on the attachments.

6.6. Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
PO Box 23076
Jackson, MS 39225-3076

6.7. 2012 ADA American Dental Association Dental Claim Form

The field instructions are as follows:

Figure 127. FL 1 Not Required: Type of Transaction

HEADER INFORMATION	
1. Type of Transaction (Mark all applicable boxes)	
<input type="checkbox"/> Statement of Actual Services	<input type="checkbox"/> Request for Predetermination/Prior Authorization
<input type="checkbox"/> EPSDT / Title XIX	

Instructions: Leave this field blank.

Figure 128. FL 2 Situational: Predetermination/Prior Authorization Number (Treatment Authorization Number)

2. Predetermination/Prior Authorization Number
A0012345

Instructions: Enter an authorization number without hyphens, dashes, spaces, etc. if entering a pre-authorized claim. Enter only one authorization per one claim form.

Figure 129. FL 3 Situational: Company/Plan Name, Address, City, Zip Code

3. Company/Plan Name, Address, City, State, Zip Code
Division of Medicaid 123 High Street Jackson, MS 30542

Instructions: Enter the name and address for the insurance company or dental benefit plan that is receiving the claim.

Figure 130. FL 4 Situational: Other Dental or Medical Coverage?

4. Dental? <input checked="" type="checkbox"/>	Medical? <input type="checkbox"/>	(If both, complete 5-11 for dental only.)
--	-----------------------------------	---

Instructions: Mark the box after “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, regardless of whether the dentist or the patient is submitting a claim to collect benefits under the other coverage. If either box is marked, complete FL 5-11.

Figure 131. FL 5 Required: Name of Policyholder/Subscriber with Other Coverage in #4

5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)
Johnson, Sarah A.

Instructions: Enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through spouse, domestic partner, or if a child, through a parent, the name of the person who has the other coverage is reported here.

Figure 132. FL 6 Not Required: Date of Birth (MM/DD/CCYY)

6. Date of Birth (MM/DD/CCYY)

Instructions: Leave this field blank.

Figure 133. FL 7 Not Required: Gender

7. Gender
<input type="checkbox"/> M <input type="checkbox"/> F

Instructions: Leave this field blank.

Figure 134. FL 8 Situational: Policyholder/Subscriber ID (SSN or ID#)

8. Policyholder/Subscriber ID (SSN or ID#)
350015555

Instructions: Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in [FL 5 \(Figure 131\)](#), which is on the identification card.

Figure 135. FL 9 Situational: Plan/Group Number

9. Plan/Group Number
456789

Instructions: Enter the group plan or policy number of the person identified in [FL 5 \(Figure 131\)](#).

Figure 136. FL 10 Situational: Patient's Relationship to Person named in #5

10. Patient's Relationship to Person named in #5				
<input checked="checked" type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent	<input type="checkbox"/> Other	

Instructions: Mark the box corresponding to the patient's relationship to the other insured name in [FL 5 \(Figure 131\)](#).

Figure 137. FL 11 Situational: Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Delta Dental 123 Main St Anywhere, MS 12345

Instructions: Enter the complete information of the additional payer, benefit plan, or entity for the insured named in [FL 5 \(Figure 131\)](#).

Figure 138. FL 12 Required: Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Johnson, Sarah A. 789 Lane Drive Moss Point, MS 34567

Instructions: Enter the complete name, address, and zip code of the Medicaid beneficiary receiving treatment.

Figure 139. FL 13 Required: Date of Birth (MM/DD/CCYY)

13. Date of Birth (MM/DD/CCYY)
01 05 1994

Instructions: Enter the Medicaid beneficiary's [from [FL 12 \(Figure 138\)](#)] date of birth with two digits for month and day and four digits for the year.

Figure 140. FL 14 Required: Gender

14. Gender	
<input type="checkbox"/> M	<input checked="checked" type="checkbox"/> F

Instructions: Mark "M" for male, or "F" for female

Figure 141. FL 15 Required: Policyholder/Subscriber ID (SSN or ID#)

15. Policyholder/Subscriber ID (SSN or ID#)
350015555

Instructions: Enter the full nine-digit identification number as listed on the policy holder's Medicaid card.

Figure 142. FL 16 Not Required: Plan/Group Number

16. Plan/Group Number

Instructions: Leave this field blank.

Figure 143. FL 17 Situational: Employer Name

17. Employer Name

Joe's Tire Shop

Instructions: Enter the name of the policyholder/subscriber's employer.

Figure 144. FL 18 Required: Relationship to Policyholder/Subscriber in #12

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

☒ Self ☐ Spouse ☐ Dependent Child ☐ Other

Instructions: Mark the relationship of the patient to the person in [FL 12 \(Figure 138\)](#) who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to [FL 24 \(Figure 150\)](#).

Figure 145. FL 19 Not Required: Reserved for Future Use

19. Reserved For Future
Use

Instructions: Leave this field blank.

Figure 146. FL 20 Not Required: Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Instructions: Leave this field blank.

Figure 147. FL 21 Not Required: Date of Birth (MM/DD/CCYY)

21. Date of Birth (MM/DD/CCYY)

Instructions: Leave this field blank.

Figure 148. FL 22 Not Required: Gender

22. Gender

☐ M ☐ F

Instructions: Leave this field blank.

Figure 149. FL 23 Not Required: Patient ID/Account # (Assigned by Dentist)

23. Patient ID/Account # (Assigned by Dentist)
--

Instructions: Leave this field blank.

Figure 150. FL 24 Required: Procedure Date (MM/DD/CCYY)

24. Procedure Date (MM/DD/CCYY)
02 21 2020
02 21 2020

Instructions: Enter the procedure date for actual services performed. A total of eight digits are required; two for month, two for the day of the month, and four for the year.

Figure 151. FL 25 Situational: Area of Oral Cavity

25. Area of Oral Cavity
10
00

Instructions: Enter the area of the oral cavity designated by a two-digit code from the following list:

- 00 – Entire oral cavity
- 01 – Maxillary arch
- 02 – Mandibular arch
- 10 – Upper right quadrant
- 20 – Upper left quadrant
- 30 – Lower left quadrant
- 40 – Lower right quadrant

Figure 152. FL 26 Not Required: Tooth System

26. Tooth System

Instructions: Leave this field blank.

Figure 153. FL 27 Situational: Tooth Number(s) or Letter(s)

27. Tooth Number(s) or Letter(s)
2
7, 8

Instructions: Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank.

If the same procedure is performed on more than a single tooth on the same date of service, report each procedure code and tooth involved on separate lines on the claim form. Supernumerary teeth in the permanent dentition are identified by tooth numbers 51 through 82; for primary dentition, supernumerary is identified by placement of the letter "S" following the letter identifying the adjacent primary tooth.

Figure 154. FL 28 Situational: Tooth Surface

28. Tooth Surface
F
D

Instructions: Enter a tooth surface code.

Figure 155. FL 29 Required: Procedure Code

29. Procedure Code
D7210
D7310

Instructions: Enter the appropriate procedure code from the current version of the ADA Current Dental Terminology Manual, Code on Dental Procedure and Nomenclature (CDT Code).

Figure 156. FL 29a Required: Diag. Pointer (Diagnosis Code Pointer)

29a. Diag. Pointer
A
B

Instructions: Enter the letter(s) from [FL 34 \(Figure 163\)](#) that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

Figure 157. FL 29b Situational: Qty. (Quantity)

29b. Qty.
1
1

Instructions: Enter the number of times (01-99) the procedure identified in [FL 29 \(Figure 155\)](#) is delivered to the patient on the date of service shown in [FL 24 \(Figure 150\)](#). The default value is "01".

Figure 158. FL 30 Not Required: Description

30. Description

Instructions: Leave this field blank.

Figure 159. FL 31 Required: Fee

31. Fee
145 00
200 00

Instructions: Enter the dentist's full fee or usual and customary charge. Do not deduct co-payment from the usual and customary charge.

Figure 160. FL 31a Situational: Other Fee(s)

31a. Other Fee(s)	10 00

Instructions: When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.

Figure 161. FL 32 Required: Total Fee

32. Total Fee	345 00
---------------	--------

Instructions: Enter the sum of all fees from lines in [FL 31 \(Figure 159\)](#) and [FL 31a \(Figure 160\)](#).

Figure 162. FL 33 Situational: Missing Teeth Information

33. Missing Teeth Information (Place an "X" on each missing tooth.)																
X	2	3	4	X	6	7	8	9	X	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Instructions: Mark an "X" on the number of the missing tooth for identifying missing permanent dentition only. Report a missing tooth/teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.

Figure 163. FL 34 Situational: Diagnosis Code List Qualifier

34. Diagnosis Code List Qualifier	A	B	(ICD-9 = B; ICD-10 = AB)
-----------------------------------	----------	----------	----------------------------

Instructions: Enter the appropriate code to identify the diagnosis code source: AB = ICD-10 CM

Figure 164. FL 34a Required: Diagnosis Code(s)

34a. Diagnosis Code(s)	A	K05.00	C	
(Primary diagnosis in "A")	B	K08.89	D	

Instructions: Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".

Figure 165. FL 35 Situational: Remarks (Used for submitting Adjustments/Replacements and Voids)

35. Remarks	Ex. 7 1022256000002 or 8 1022256000002
-------------	--

Instructions: Enter a 7 to indicate an adjustment/replacement or enter an 8 to indicate a void preceding the ICN or TCN to be adjusted

Figure 166. FL 36 Required: Patient/Guardian Signature

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.	
X	MM/DD/YYY
Add Signature or Signature on File (SOF)	
Patient/Guardian Signature	Date

Instructions: By signing in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment, and the release of any information necessary to carry out payment activities related to the claim.

In lieu of having the beneficiary sign a claim form on each visit, the provider may retain a copy of a statement of release signed by the beneficiary or his/her guardian. Medicaid allows a beneficiary signature for a lifetime when the provider has a signature authorization on file. On the claim form, the provider would enter "Signature on File" to satisfy the signature guidelines. If the beneficiary is unable to sign, the billing clerk may sign the beneficiary's name and indicate "By: (name of office person signing)". In addition, the reason the beneficiary is not able to sign must be specified.

Claim forms prepared by the dentist's practice software may insert "Signature on File" when applicable in this item.

Note: Red ink should not be used for the signature.

Figure 167. FL 37 Not Required: Subscriber Signature

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	
X	
Subscriber Signature	Date

Instructions: Leave this field blank.

Figure 168. FL 38 Required: Place of Treatment

38. Place of Treatment **11** (e.g. 11=office; 22=O/P Hospital)(Use
"Place of Service Codes for Professional Claims")

Instructions: Enter the two-digit Place of Service Code for Professional Claims; this is a HIPAA standard. A complete list of the Place of Service Codes is available at:
[www.cms.gov/Medicare/Coding/place-of-service-codes/Place of Service Code Set.html](http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html).

Figure 169. FL 39 Not Required: Enclosures

39. Enclosures (Y or N) ☐

Instructions: Leave this field blank.

Figure 170. FL 40 Not Required: Is Treatment for Orthodontics?

40. Is Treatment for Orthodontics?

☐

No (Skip 41-42)

☐

Yes (Complete 41-42)

Instructions: Leave this field blank.

Figure 171. FL 41 Not Required: Date Appliance Placed (MM/DD/CCYY)

41. Date Appliance Placed (MM/DD/CCYY)

Instructions: Leave this field blank.

Figure 172. FL 42 Not Required: Months of Treatment

42. Months of Treatment

Instructions: Leave this field blank.

Figure 173. FL 43 Not Required: Replacement of Prosthesis

43. Replacement of Prosthesis

☐

No

☐

Yes (Complete 44)

Instructions: Leave this field blank.

Figure 174. FL 44 Not Required: Date of Placement (MM/DD/CCYY)

44. Date of Prior Placement (MM/DD/CCYY)

Instructions: Leave this field blank.

Figure 175. FL 45 Situational: Treatment Resulting from?

45. Treatment Resulting from		
<input type="checkbox"/> Occupational illness/injury	<input type="checkbox"/> Auto accident	<input type="checkbox"/> Other accident

Instructions: If dental treatment is listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to [FL 46 \(Figure 176\)](#) and [FL 47 \(Figure 177\)](#). If the services you are providing are not the result of an accident, this field does not apply; skip to [FL 48 \(Figure 178\)](#).

Figure 176. FL 46 Situational: Date of Accident (MM/DD/CCYY)

46. Date of Accident (MM/DD/CCYY)

Instructions: Enter the date on which the accident noted in [FL 45 \(Figure 175\)](#) occurred. Otherwise, leave blank.

Figure 177. FL 47 Situational: Auto Accident State

47. Auto Accident State

Instructions: Enter state where the auto accident occurred.

Figure 178. FL 48 Required: Name, Address, City, State, Zip Code

48. Name, Address, City, State, Zip Code
University Dentists 2500 North State Street Jackson, MS 39216

Instructions: Enter the name and complete address of the billing dentist or dental entity (group, corporation, etc.)

Figure 179. FL 49 Required: NPI

49. NPI
0123456789

Instructions: Enter the appropriate ten-digit NPI number for the billing entity. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.

Figure 180. FL 50 Not Required: License Number

50. License Number

Instructions: Leave this field blank.

Figure 181. FL 51 Not Required: SSN or TIN

51. SSN or TIN

Instructions: Leave this field blank.

Figure 182. FL 52 Not Required: Phone Number

52. Phone Number

Instructions: Leave this field blank.

Figure 183. FL 52a Situational: Additional Provider ID

52a. Additional
Provider ID

Instructions: Enter the qualifier ZZ followed by the Taxonomy code, if the NPI was used in [FL 49 \(Figure 179\)](#). Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the dental provider.

Figure 184. FL 53 Required: Certification

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Add Signature or Signature on File (SOF) MM/DD/YYYY
Signed (Treating Dentist) Date

Instructions: Enter the signature of the treating or rendering dentist and the date the form was signed. The provider must sign and date the claim form; a rubber stamp signature is acceptable. The provider is certifying that it is understood that payment and satisfaction of the claim is from federal or state funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws. Claim forms prepared by the dentist's management software may insert the treating dentist's printed name in this item.

Note: Red ink should not be used for the signature.

Figure 185. FL 54 Required: NPI

54. NPI 4567891230

Instructions: Enter the appropriate ten-digit NPI number for the treating dentist. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.

Figure 186. FL 55 Not Required: License Number

55. License Number

Instructions: Leave this field blank.

Figure 187. FL 56 Not Required: Name, Address, City, State, Zip Code

56. Address, City, State, Zip Code

Instructions: Leave this field blank.

Figure 188. FL 56a Required: Provider Specialty Code

56a. Provider
Specialty Code

Instructions: Enter the code that indicates the type of dental professional who delivered the treatment. Provider specialty codes, also known as "provider taxonomy codes," come from Dental Service Provider section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. The valid values for the specialty code are in the following figure.

Figure 189. Provider Specialty Codes

Source	Description
Dentist	122300000X
General Practice	1223G0001X
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Figure 190. FL 57 Not Required: Phone Number

57. Phone Number

Instructions: Leave this field blank.

Figure 191. FL 58 Situational: Additional Provider ID

58. Additional Provider ID

Instructions: Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number.

Figure 192. ADA Dental Claim Form (Version 2012)

ADA American Dental Association* Dental Claim Form										Medicare Advantage																																																																																																															
HEADER INFORMATION																																																																																																																									
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> EPSDT / Title XIX																																																																																																																									
2. Predetermination/Preauthorization Number																																																																																																																									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																																																																																																																									
3. Company/Plan Name, Address, City, State, Zip Code																																																																																																																									
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																																																																																																																									
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only)																																																																																																																									
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																																																									
6. Date of Birth (MM/DD/YYYY)																																																																																																																									
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F																																																																																																																									
8. Policyholder/Subscriber ID (SSN or IC#)																																																																																																																									
9. Plan/Group Number																																																																																																																									
10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																																																									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																																																									
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																																																																																																																									
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																																																									
13. Date of Birth (MM/DD/YYYY)																																																																																																																									
14. Gender <input type="checkbox"/> M <input type="checkbox"/> F																																																																																																																									
15. Policyholder/Subscriber ID (SSN or IC#)																																																																																																																									
16. Plan/Group Number																																																																																																																									
17. Employer Name																																																																																																																									
PATIENT INFORMATION																																																																																																																									
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																																																																																																																									
19. Reserved For Future Use																																																																																																																									
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																																																									
21. Date of Birth (MM/DD/YYYY)																																																																																																																									
22. Gender <input type="checkbox"/> M <input type="checkbox"/> F																																																																																																																									
23. Patient ID/Account # (Assigned by Dental)																																																																																																																									
RECORD OF SERVICES PROVIDED																																																																																																																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>24. Procedure Date (MM/DD/YYYY)</th> <th>25. Area of Oral Cavity</th> <th>26. Tooth System</th> <th>27. Tooth Number(s) or Letter(s)</th> <th>28. Tooth Surface</th> <th>29. Procedure Code</th> <th>29a. Prep. Poles</th> <th>29b. Qty</th> <th>30. Description</th> <th>31. Fee</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>												24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Prep. Poles	29b. Qty	30. Description	31. Fee	1										2										3										4										5										6										7										8										9										10									
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BILLING DENTIST OR DENTAL ENTITY (Leave blank if dental or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																																																																																																																									
45. Name, Address, City, State, Zip Code																																																																																																																									
46. NPI _____ 50. License Number _____ 51. SSN or TIN _____																																																																																																																									
52. Phone Number _____ 53a. Additional Provider ID _____																																																																																																																									
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38. Place of Treatment (e.g. In-office; 22-Off Hospital) (Use "Place of Service Codes for Professional Claims") <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																																																									
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41. Date Appliance Placed (MM/DD/YYYY)																																																																																																																									
42. Months of Treatment _____ 43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																																																									
44. Date of Prior Placement (MM/DD/YYYY)																																																																																																																									
45. Treatment Resulting from <input type="checkbox"/> Occupational Injuries <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																																																									
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57. Phone Number _____ 58. Additional Provider ID _____																																																																																																																									

6.8. Filing Medicare Crossover Claims on the Dental Claim Form

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

Effective October 1, 2025, Mississippi Medicaid will require use of the MS Medicaid Crossover Cover Sheet for all crossover claims submitted via paper. Paper claims submitted without the

new form and the Explanation of Medicare Benefits (EOMB) or completed incorrectly will be returned unprocessed.

Proper completion of this form allows Gainwell to accurately scan and key your paper claim with the correct claim type and filing indicators—ensuring faster and more accurate processing. The updated form and instructions are available under the “Provider Forms” section of DOM’s website: <https://medicaid.ms.gov/resources/forms/>.

Providers are required to submit a separate Medicare Crossover form for each payer that has processed the claim prior to Mississippi XIX (also known as a “primary payer”). Primary payers may be Medicare A, Medicare B, or Medicare C/ Advantage. Please refer to MS Medicare Crossover Sheet (Cover page) for instructions.

- The beneficiary’s Medicare number should be entered in [FL 12 \(Figure 138\)](#).
- The beneficiary’s nine-digit Medicaid number should be entered in [FL 15 \(Figure 141\)](#).
- The ten-digit NPI number should be entered in [FL 49 \(Figure 179\)](#).
- Optional: The nine-digit Medicaid provider number should be entered in [FL 52A \(Figure 183\)](#).
- The claim detail information should match the individual EOMB detail level information. Claims will deny if more details are listed on the EOMB.
- Enter the claim details in the order listed on the EOMB.
- The corresponding claim information should be circled on the EOMB and redact all claims information that is not relevant to the claim and attach the EOMB to the back of the claim.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider must line out or redact patient data not applicable to the claim submitted.
- The provider must line out or redact any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- Highlighting must not be used to indicate the information from the EOMB that applies to the claim.