# 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. |
| 3.0 | 10/13/2022 | Gainwell | Updated Figure 1. FL 1 Required: Type of Insurance, Figure 83. FL 38 Situational: Responsible Party Name and Address, Section 5.9, Figure 124: FL 80 Situational Remarks, Section 5.9, and Section 6.8. |
| 4.0 | 10/17/2022 | Gainwell | Updated links in section 4.5. |
| 5.0 | 11/03/2022 | Gainwell | Updated Figure 125. FL 81 Not Required: Code-Code Field. |
| 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. |
| 7.0 | 06/07/2023 | Gainwell | Updated sections 4.4, 4.9, 5.5, 5.8, 5.9, 6.5, and 6.8 |
| 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.<br><br>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<br>Jackson, MS 39225 | Paper Claims CMS-1500, UB-04, and Dental (including crossover claims) |
| PO Box 23077<br>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

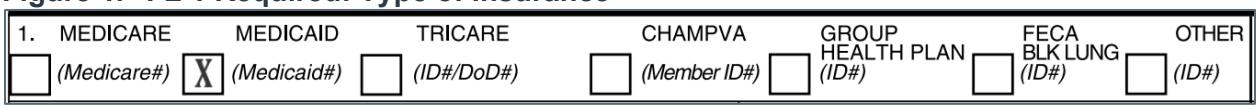
PO Box 23076

Jackson, MS 39225-3076

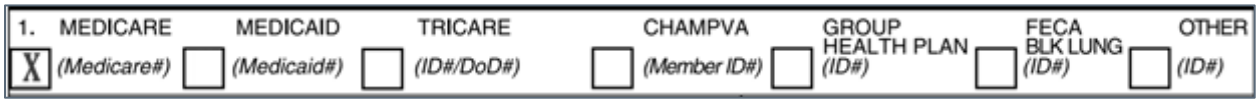
## 4.8. CMS-1500 Claim Form Instructions (Version 02/12)

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**

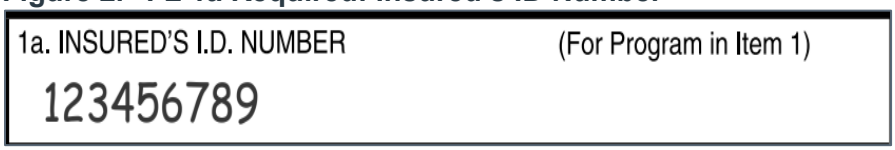



Instructions: Indicate the type(s) of insurance coverage applicable to this claim. Enter an “X” in the box marked Medicaid.




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**




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 MM 01 | DD 01 | YY 1991 SEX M [X] F [ ]

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)

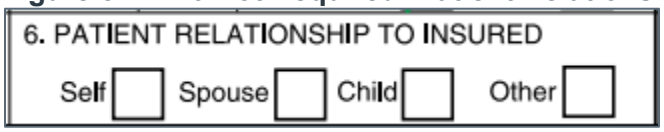
Instructions: Leave this field blank.

**Figure 7. FL 5 Not Required: Patient Address**

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

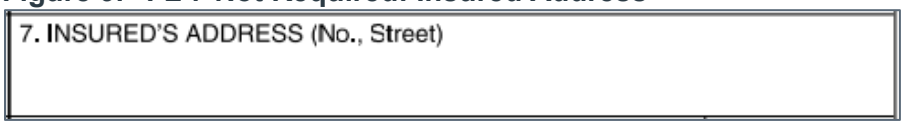
Instructions: Leave this field blank.

**Figure 8. FL 6 Not Required: Patient Relationship**



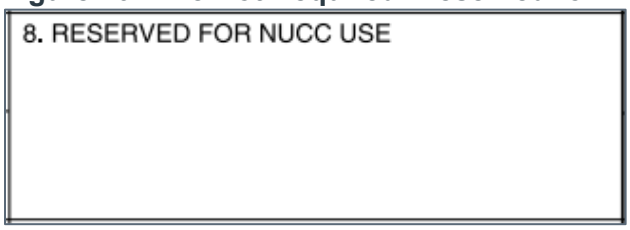

Instructions: Leave this field blank.

**Figure 9. FL 7 Not Required: Insured Address**



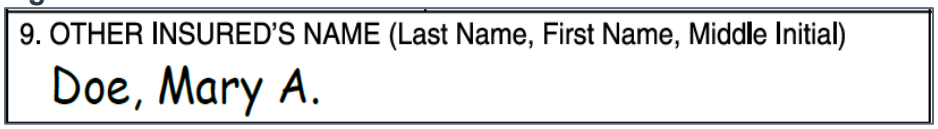

Instructions: Leave this field blank.

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



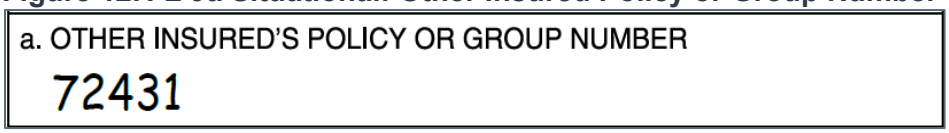

Instructions: Leave this field blank.

**Figure 11. FL 9 Situational: Other Insured Name**




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.

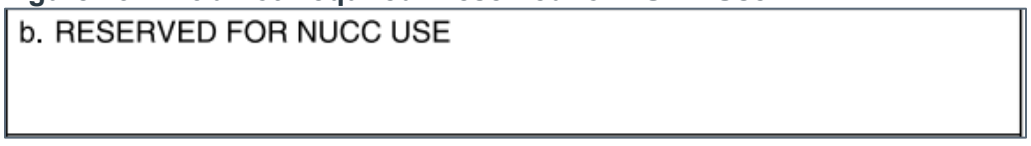
**Figure 12. FL 9a Situational: Other Insured Policy or Group Number**




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**

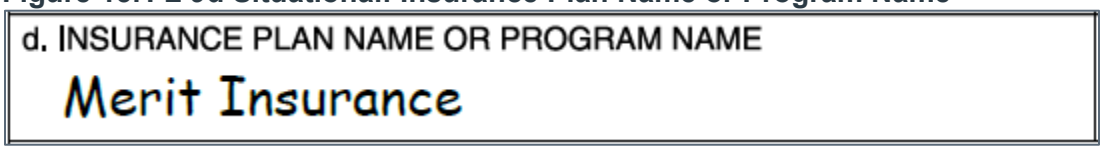



Instructions: Leave this field blank.

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


Instructions: Leave this field blank.

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



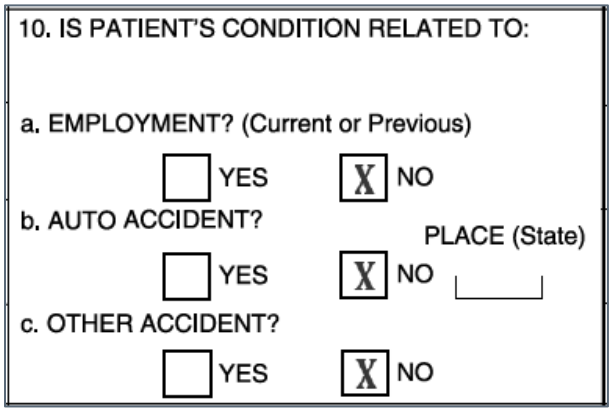

Instructions: Enter the other insured's insurance plan or program name.

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

a. Employment?

b. Auto Accident?

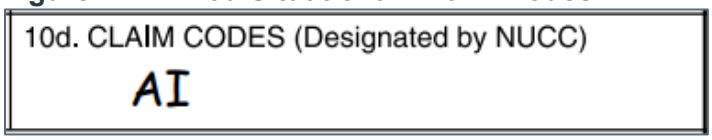
c. Other Accident?




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.

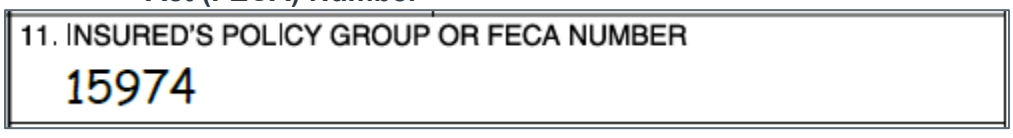
Note: Enter the State code if 10b. is checked "YES". Any item checked "YES" indicates there may be other insurance primary to Medicaid. Identify primary insurance information in FL 11 (Figure 18).

**Figure 17. FL 10d Situational: Claim Codes**




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**

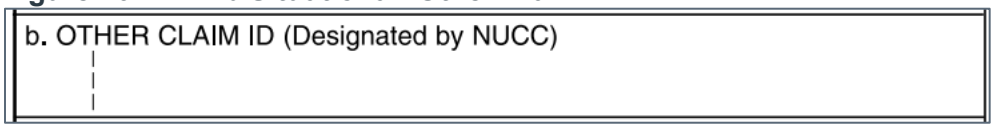



Instructions: Enter the insured's policy or group number as it appears on the insured's healthcare identification card.

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

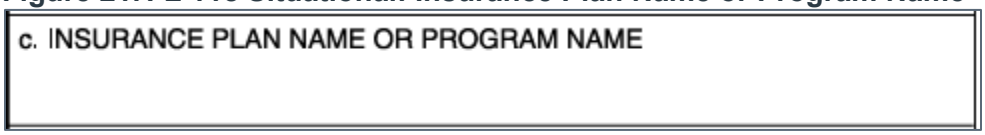

Instructions: Leave this field blank.

**Figure 20. FL 11b Situational: Other Claim ID**



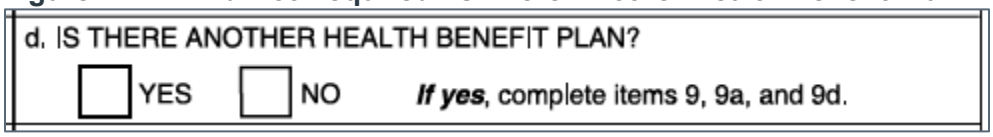

Instructions: When applicable, use to report appropriate Other Claim ID. Applicable Other Claim ID are designated by the NUCC under Code Set https://www.nucc.org/.

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



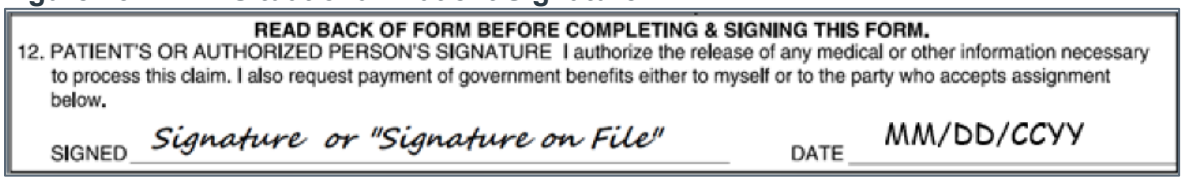

Instructions: Enter the other insured's insurance plan or program name.

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



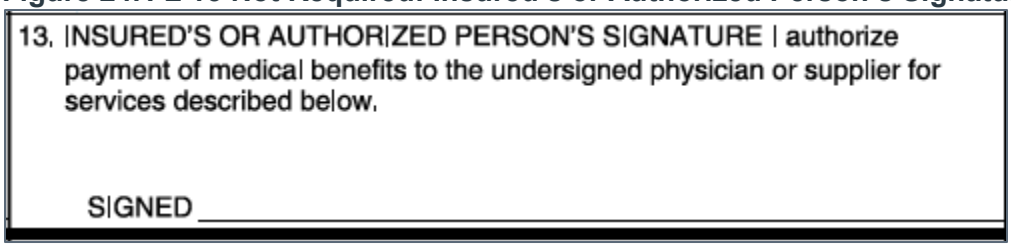

Instructions: Leave this field blank.

**Figure 23. FL 12 Situational: Patient Signature**



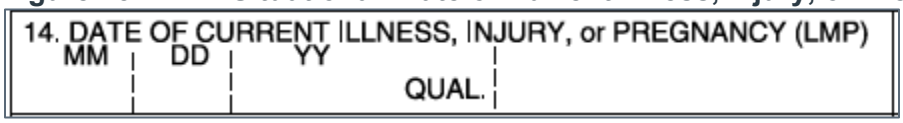

Instructions: Enter the member signature or signature on file with the date in MM/DD/CCYY format.

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




Instructions: Leave this field blank.

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

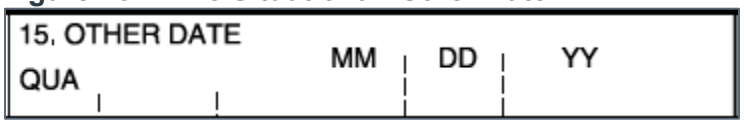



Instructions: For current illness, injury, or pregnancy, enter the date in the MM/DD/CCYY format.

Valid Values:

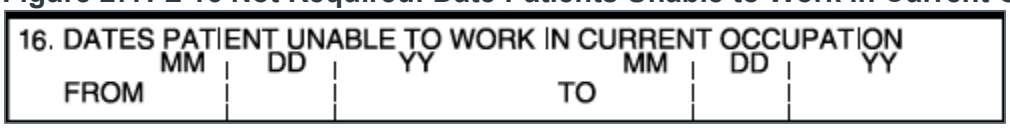
- 431 = Onset of current symptoms or illness
- 439 = Injury
- 484 = LMP

**Figure 26. FL 15 Situational: Other Date**



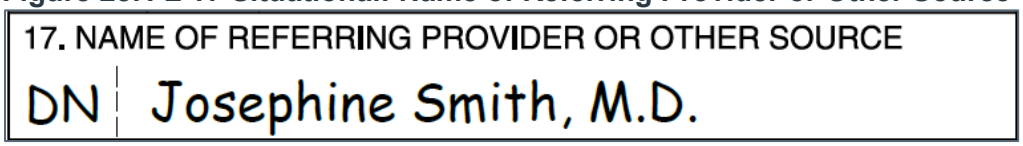

Instructions: Enter other date in the MM/DD/CCYY format. Applicable Qualifiers are designated by the NUCC under Code Set https://www.nucc.org/.

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




Instructions: Leave this field blank.

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




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.

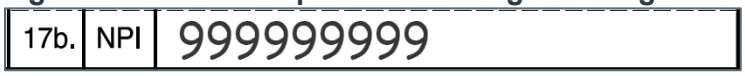
**Figure 29. FL 17a Required: Other ID Number**


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

Qualifier valid values are:

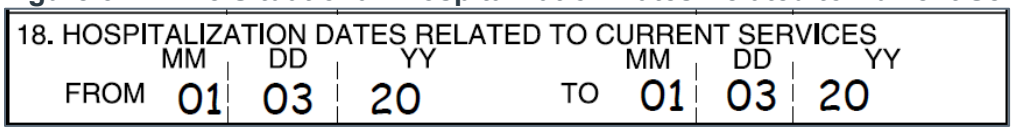
- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Medicaid ID
- LU – Location Number (Used for Supervising Provider only)
- ZZ – Taxonomy

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



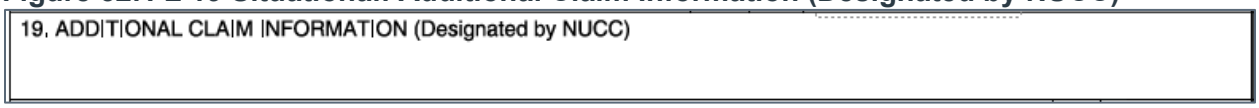

Instructions: Enter the ten-digit NPI number.

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



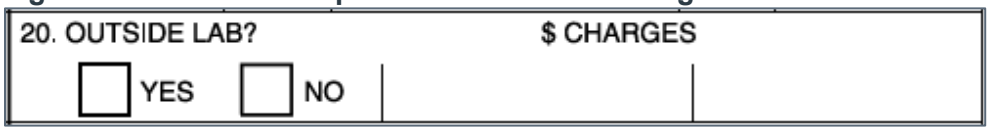

Instructions: Enter the date of hospital admission and discharge if the services billed are related to a hospitalization. If the patient has not been discharged, leave the discharge date blank.

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



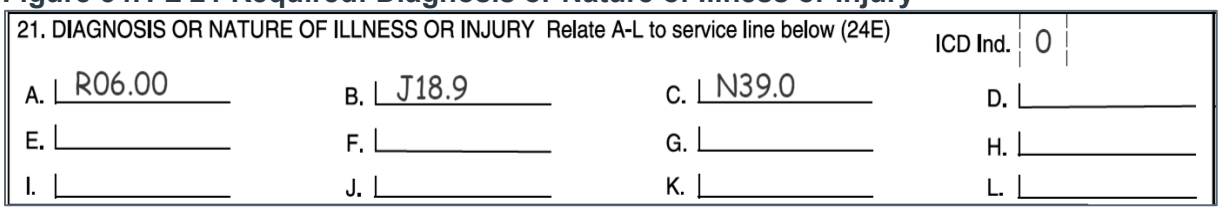

Instructions: Use this field for when submitting a multi-page claim to indicate page count X of 9.

**Figure 33. FL 20 Not Required: Outside Lab Charges**




Instructions: Leave this field blank.

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




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.)**


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

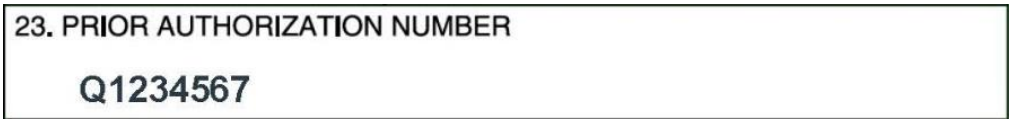
Resubmission Codes Valid Values are:

- 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.

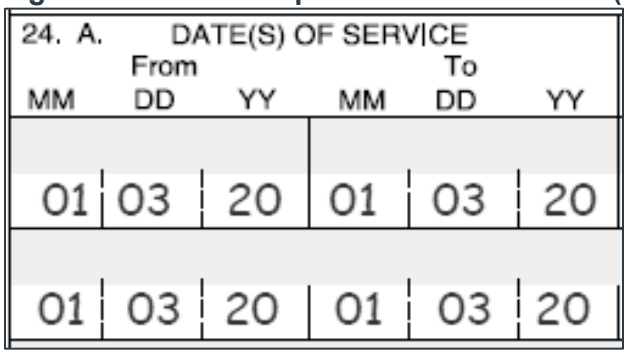
**Figure 36. FL 23 Situational: Prior Authorization Number**



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

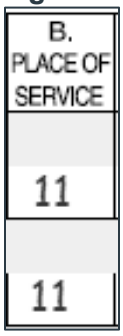
Services requiring prior authorization will deny if PA number is missing, incomplete, units billed exceeds the authorized units, etc.

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




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**

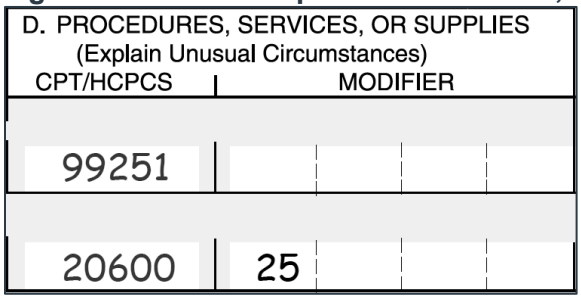



Instructions: Enter the appropriate two-digit code for the place of service code. The Place of Service Codes are available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

**Figure 39. FL 24c Situational: EMG**


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

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

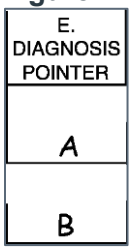



Instructions: Enter the following information:

- **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.)

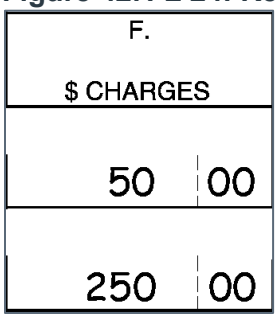
Note: Some mental health providers are required to enter a specific modifier for each claim line. Fee schedules identifying modifier requirements are available at: Fee Schedules and Rates.

**Figure 41. FL 24e Required: Diagnosis Pointer**



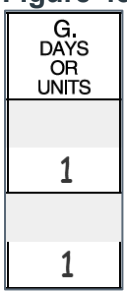

Instructions: Enter one diagnosis indicator (A, B, C, D, E, F, G, H) that identifies appropriate diagnosis for the procedures. These indicators should correspond to the line numbers of the diagnosis codes listed in FL 21 (Figure 34).

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




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**

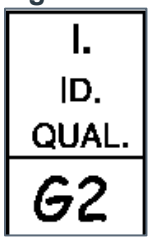



Instructions: Enter the number of days or units. This field is most used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

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


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**

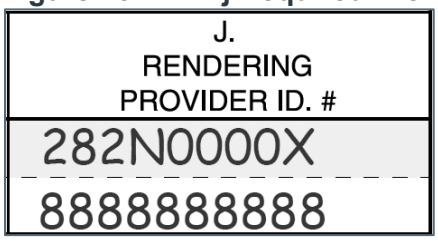



Instructions: Enter the appropriate qualifier to identify if the number is a non-NPI.

Qualifier valid values are:

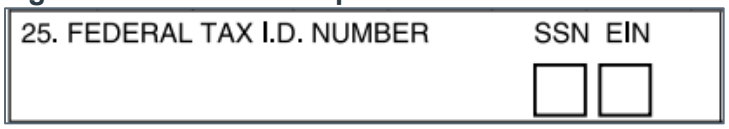
- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Medicaid ID
- LU – Location Number (Used for Supervising Provider only)
- ZZ – Taxonomy

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



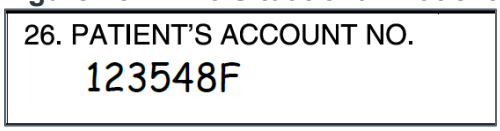

Instructions: Enter the rendering provider’s Taxonomy (ZZ) or related value to the qualifiers (0B, 1G, G2, and LU) in the shaded half of the claim line. Enter the ten-digit NPI in the bottom, (un-shaded half of the claim line).

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



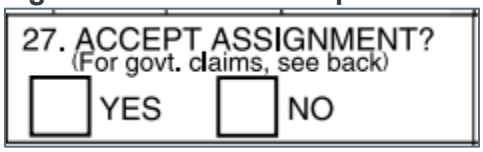

Instructions: Leave this field blank.

**Figure 48. FL 26 Situational: Patient Account Number**



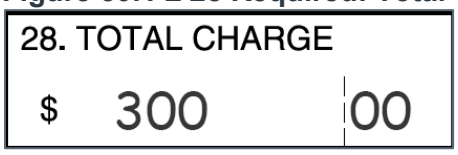

Instructions: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist the provider in patient identification.

**Figure 49. FL 27 Not Required: Accept Assignment?**



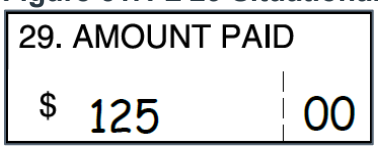

Instructions: Leave this field blank.

**Figure 50. FL 28 Required: Total Charge**



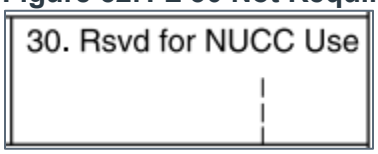

Instructions: Enter total charges for the services [i.e., total of all charges in FL 24f (Figure 42)].

**Figure 51. FL 29 Situational: Amount Paid**



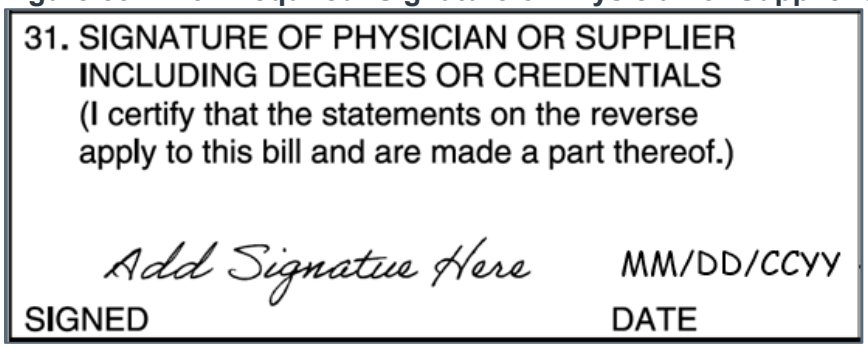

Instructions: Enter total amount the member and/or other payers paid on the covered services only.

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



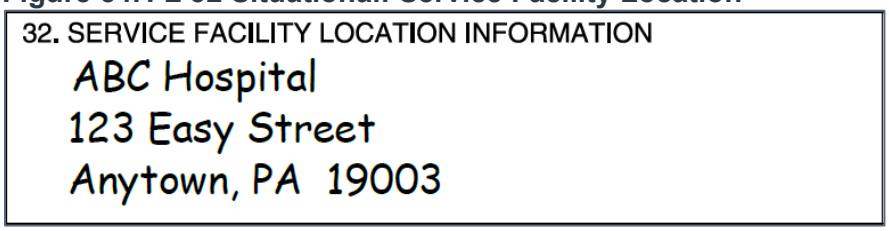

Instructions: Leave this field blank.

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

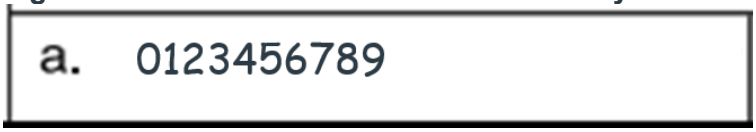
**Figure 54. FL 32 Situational: Service Facility Location**




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

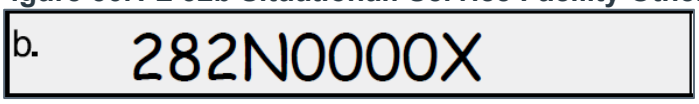
- Facility Name
- Street Address
- City, State Zip Code

**Figure 55. FL 32a Situational: Service Facility NPI**



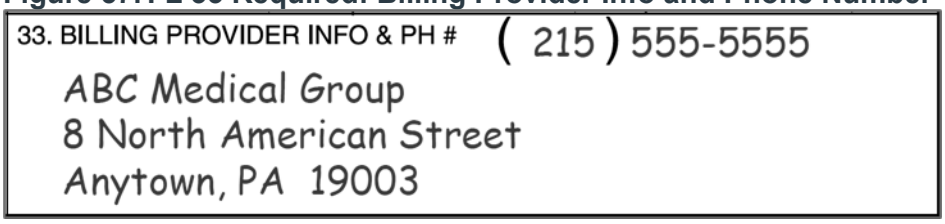

Instructions: Enter the NPI of the servicing provider.

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



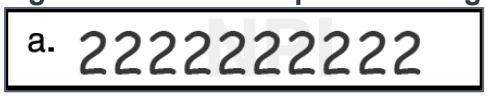

Instructions: Enter the qualifier ZZ followed by the Taxonomy code if the NPI was used in FL 32a. Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

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




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**



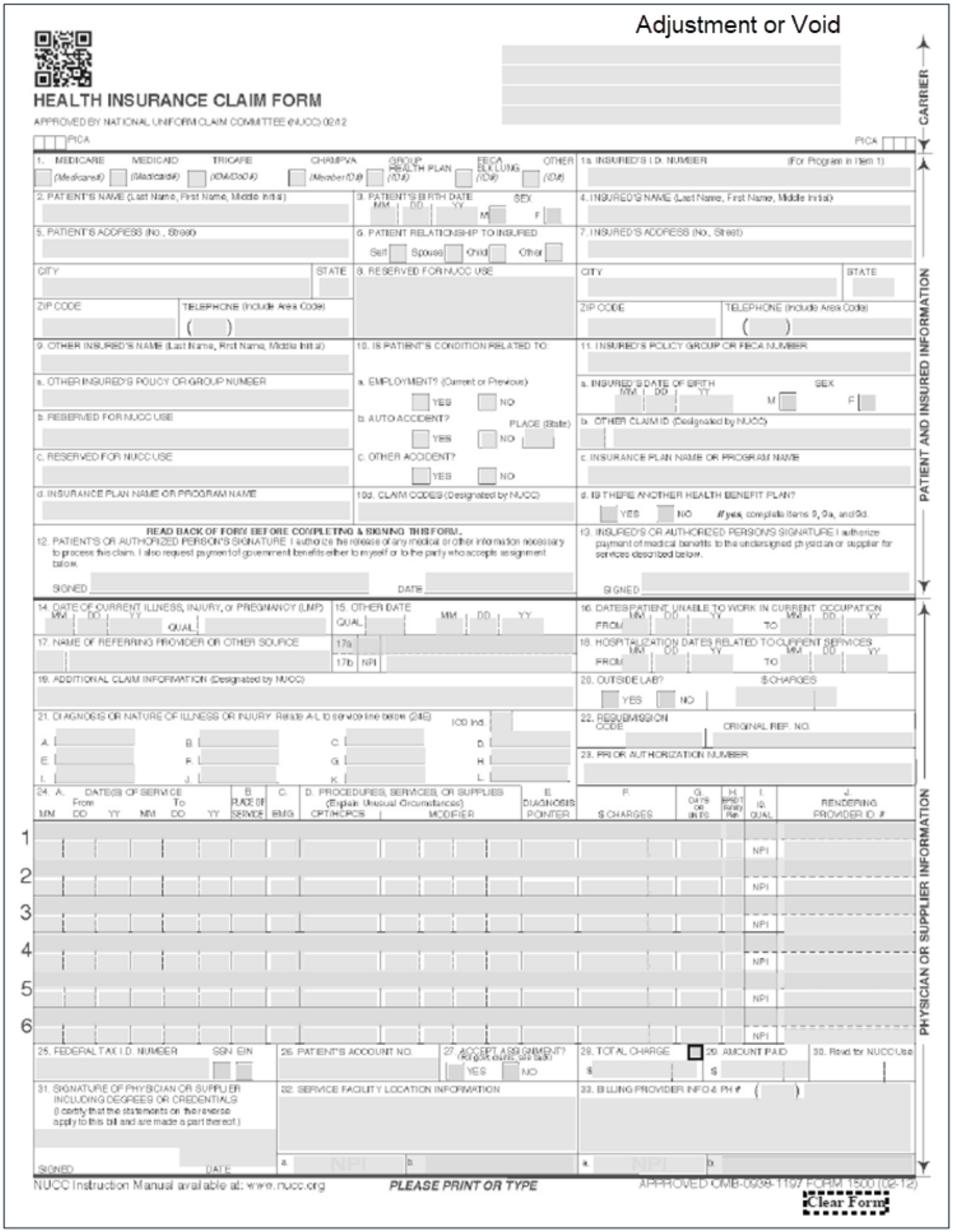

Instructions: Enter the NPI of the billing provider.

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

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


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



## 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

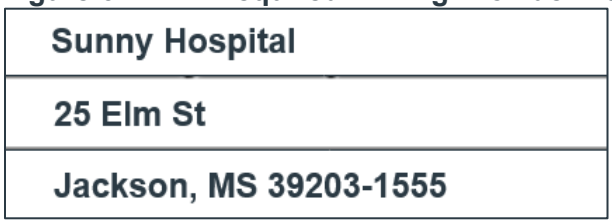
PO Box 23076

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**

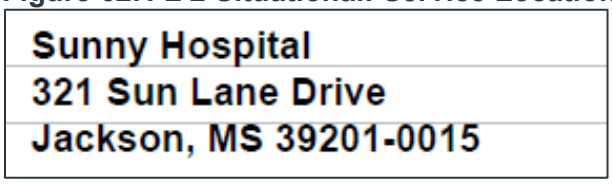



Instructions: Enter the billing provider name and physical address (including the expanded ZIP Code+4) currently on file with DOM as follows:

***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**




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

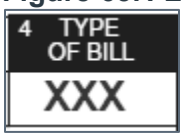
**Figure 63. FL 3a Situational: Patient Control Number**


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**

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**




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 |

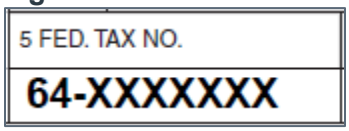
**Table 6. Bill Classification – Special Facilities Only (Second Digit) Code Values**

| 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**

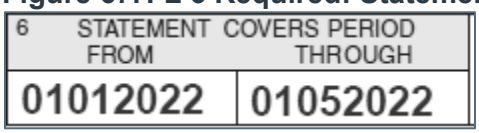
| Frequency (Third Digit) | Code |
|---|---|
| Non-Payment/Zero Claim | 0 |
| Admit Through Discharge | 1 |
| Interim, First Claim | 2 |
| Interim, Continuing Claim | 3 |
| Interim, Last Claim | 4 |
| Late Charge(s) Only Claim | 5 |
| Replacement of Prior Claim | 7 |
| Void/Cancel of Prior Claim | 8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

**Figure 66. FL 5 Situational: Federal Tax Number**




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)**




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 |

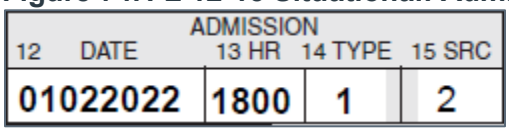
Instructions: Enter the month, day, and year of birth of patient. The date format is eight digits [MMDDCCYY (e.g., 03201971)].

**Figure 73. FL 11 Required: Patient Sex**


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**




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.

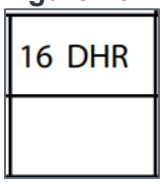
- FL 15: Admission Source – Enter the code indicating the source of the referral for the admission or visit. Required for all inpatient and outpatient services.

**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 |

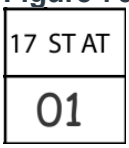
* Requires NPI in FL 76

**Figure 75. FL 16 Not Required: Discharge Hour**




Instructions: Leave this field blank.

**Figure 76. FL 17 Required: Patient Discharge Status**



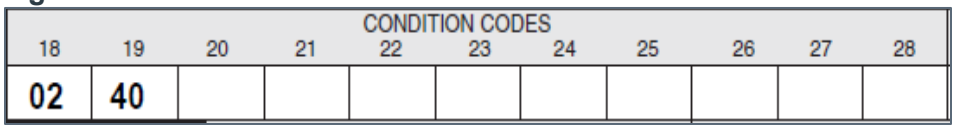

Instructions: Enter the member's disposition or discharge status at the end of service for the period covered on this bill, as reported in FL 6, (Figure 67). The valid values and their descriptions for this field are listed in the following table.

**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) |

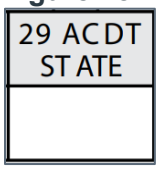
| Patient Status | Description |
|---|---|
| 05 | DISCHARGED/TRANSFERRED TO A DESIGNATED CANCER CENTER OR CHILDRENS HOSPITAL |
| 06 | DISCHARGED/TRANSFERRED HOME UNDER CARE OF ORGANIZED HH SVC ORG IN ANTICIPATION OF COVD SKILLED CARE |
| 07 | LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE |
| 08 | 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**



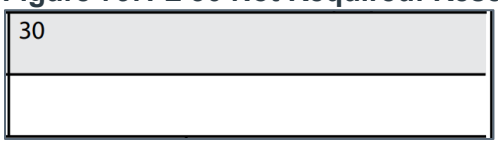

Instructions: Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. This field is required when there is a Condition Code that applies to this claim.

**Figure 78. FL 29 Not Required: Accident State**




Instructions: Leave this field blank.

**Figure 79. FL 30 Not Required: Reserved**




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 | | | | | | |

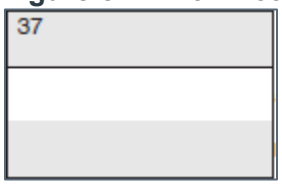
Instructions: Enter the Occurrence code and date. The date format is eight digits [MMDDCCYY (e.g., 01012022)]. This field is required when there is a significant occurrence (event) relating to this claim. Event codes should be submitted in alphanumeric sequence.

**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 alpha-numeric digits; dates are shown numerically as MMDDCCYY through MMDDCCYY.

**Figure 82. FL 37 Not Required: Reserved**

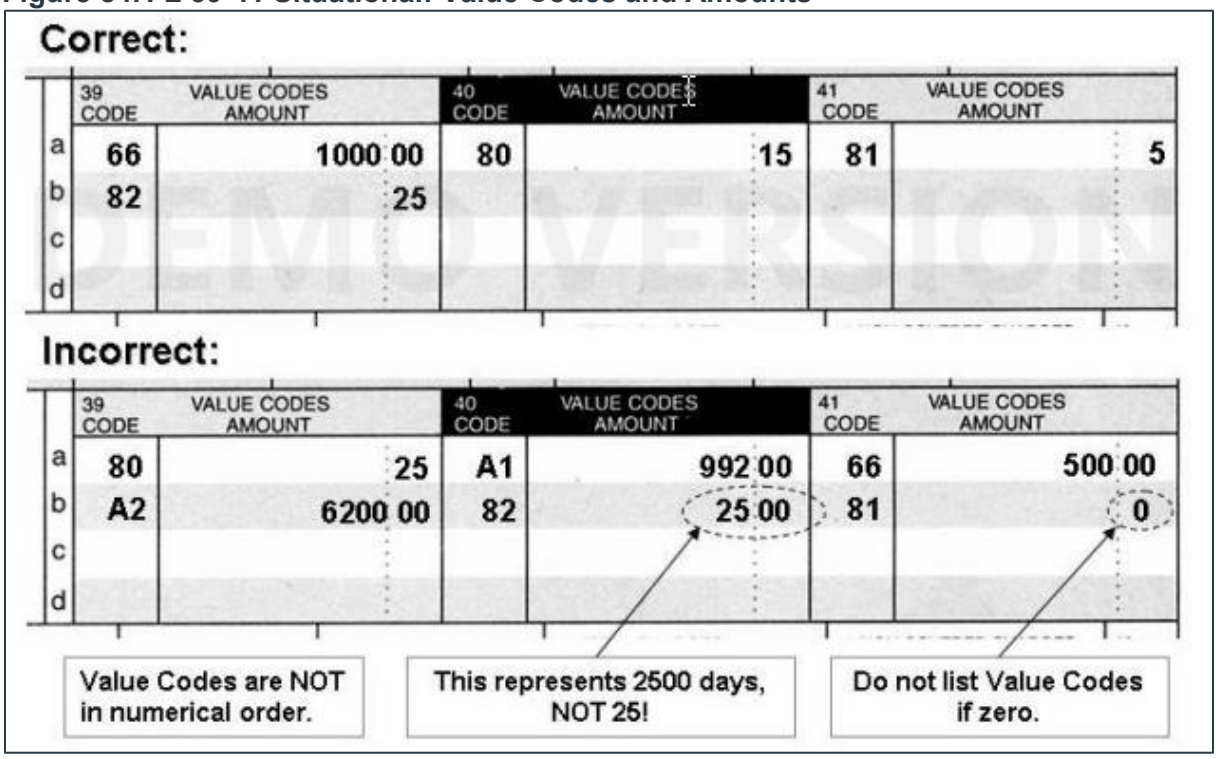



Instructions: Leave this field blank.

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


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**




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

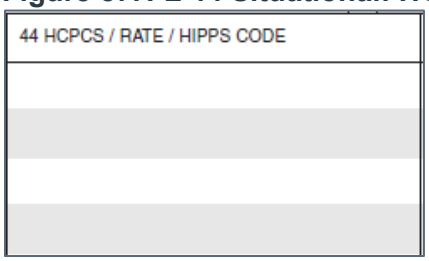
ME – Milligram

ML – Milliliter

UN – Unit

Example N400023114501UN

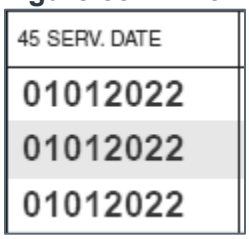
**Figure 87. FL 44 Situational: HCPCS/Rate/HIPPS Code**




Instructions: Enter the following when applicable:

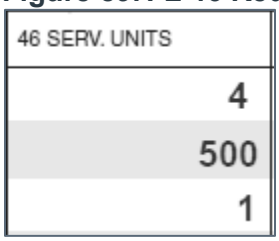
1. The HCPCS codes applicable to the ancillary service and outpatient bills
2. The accommodation rate for inpatient bills
3. The Health Insurance Prospective Payment System (HIPPS) rate codes that represent specific set of patient characteristics (or case-mix groups) on which payment determinations are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

**Figure 88. FL 45 Required: Service Date**



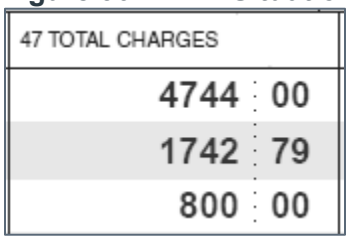

Instructions: Enter the month, day, and year the member service was provided. The date format is eight digits [MMDDCCYY (e.g., 01012022)].

**Figure 89. FL 46 Required: Service Units**



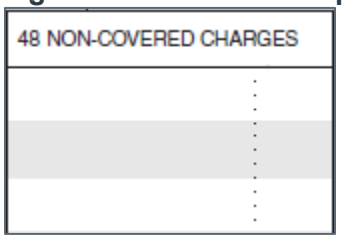

Instructions: Enter the quantitative measure of services rendered for each procedure or revenue code for the total number of covered accommodation days, ancillary units of service, or visits, where appropriate. When a decimal is used, the maximum number of digits allowed to the right of the decimal is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

**Figure 90. FL 47 Situational: Total Charges**




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**

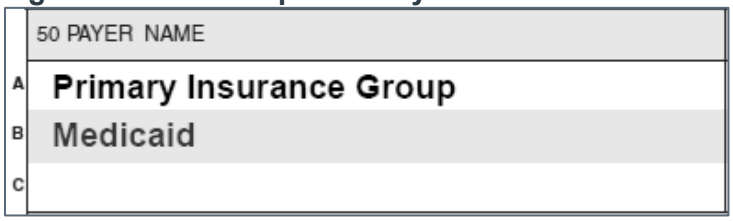



Instructions: Leave this field blank.

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

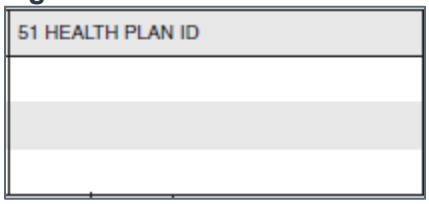

Instructions: Leave this field blank.

**Figure 93. FL 50 Required: Payer Name**




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.

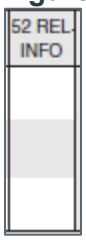
**Figure 94. FL 51 Situational: Payer ID**




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.

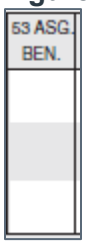
**Figure 95. FL 52 Situational: Claim Filing Indicator Code**




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

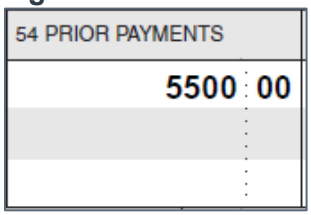
Note: Use a value of ‘MA’ or ‘MB’ to identify Medicare Payers, or use ‘16’ to identify Medicare C Advantages Plan. For any Commercial Insurance payer, use a value of “CI’ to identify TPL Payer.

**Figure 96. FL 53 Situational: Assignment of Benefits**



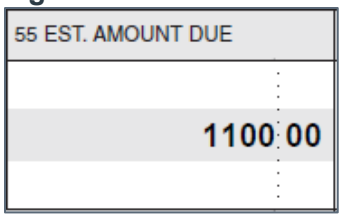

Instructions: Enter the assignment of benefits. Valid values are “N” for No and “Y” for Yes.

**Figure 97. FL 54 Situational: Prior Payments**



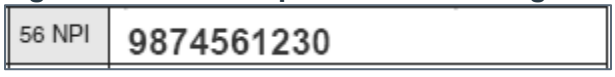

Instructions: Enter payment(s) received from any other insurance carriers for claim services.

**Figure 98. FL 55 Situational: Estimated Amount Due**



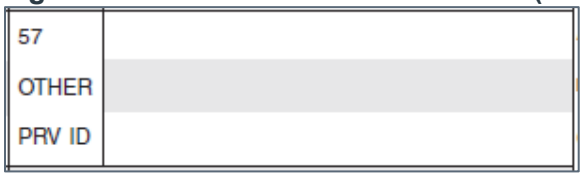

Instructions: Enter the amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

**Figure 99. FL 56 Required: NPI – Billing Provider**



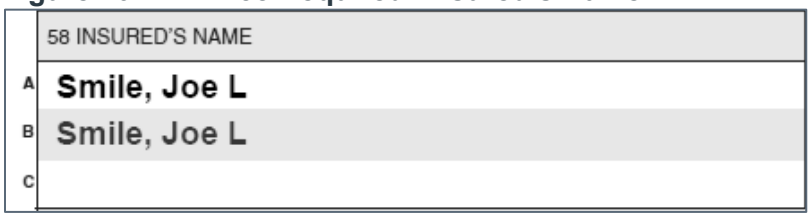

Instructions: Enter the unique identification number assigned to the provider submitting the bill. This is a 10-digit number that will be used to identify you to your health care partners including all payers.

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



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**

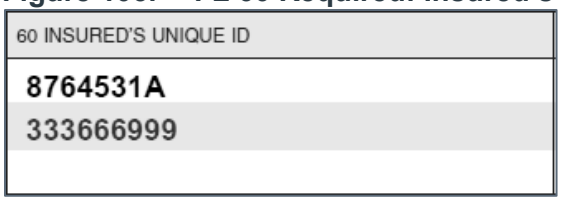



Instructions: Enter the name of the individual under whose name the insurance benefit is carried. Enter the policyholder's last name, first name, and middle initial. Entering incorrect information will result in claim denial(s).

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

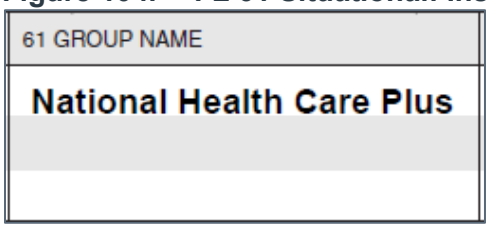

Instructions: Leave this field blank.

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



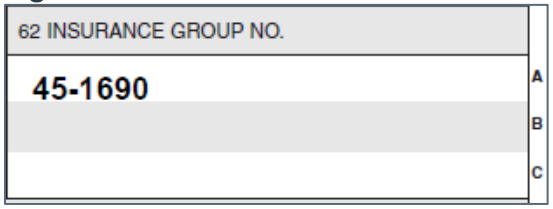

Instructions: Enter the unique number assigned by the health plan to the insured if there is another health plan, as well as entering the Members Medicaid ID.

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



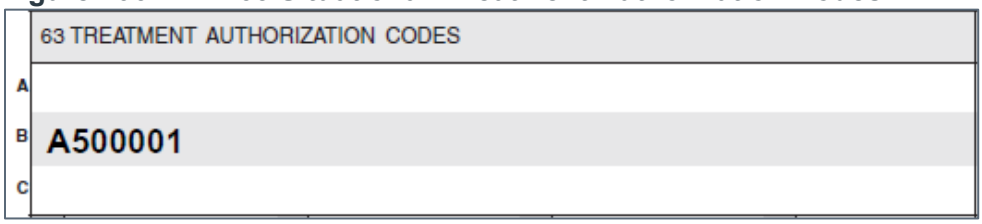

Instructions: Enter the group name or plan providing the member's primary, secondary, and tertiary insurance on lines A, B, and C according to proper billing order, exactly as it appears on the health insurance card. Do not enter a group name on the line that shows payor, "Medicaid". This field is required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

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



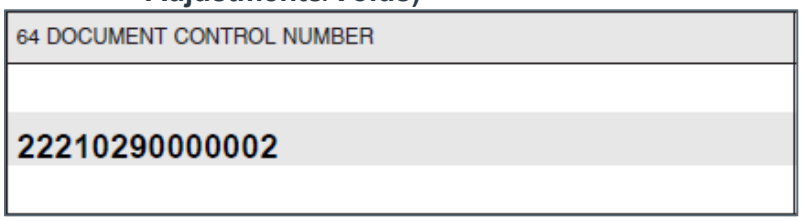
Instructions: Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered. Enter the member's primary, secondary, and tertiary insurance on Lines A, B and C, according to proper billing order.

**Figure 106. FL 63 Situational: Treatment Authorization Codes**



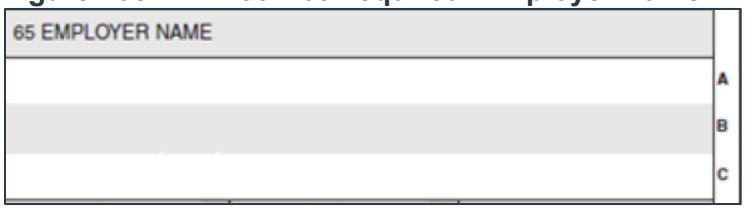

Instructions: Enter the authorization number in this field. Only one authorization number may be entered per claim. This field is required when an authorization code assigned by the Utilization Management Organization is required to be reported on the claim.

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



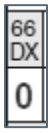

Instructions: Enter the original claim ICN that is being requested to be replaced/adjusted or voided. This field is required when the TOB Frequency [FL 4 (Figure 65)] indicates this claim is a replacement/adjusted (7) or void (8) to a previously adjudicated claim. Additionally, please indicate "Adjustment"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

**Figure 108. FL 65 Not Required: Employer Name**



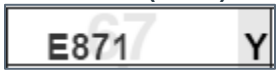

Instructions: Leave this field blank.

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




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**




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**

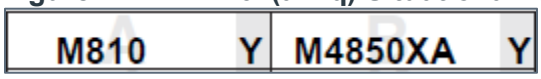
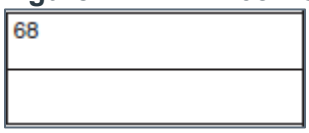
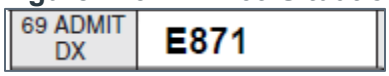



**Figure 112. FL 68 Not Required: Reserved for Assignment by the NUBC**




Instructions: Leave this field blank.

**Figure 113. FL 69 Situational: Admitting Diagnosis Code**

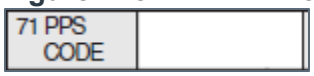



Instructions: Enter the ICD diagnosis code, appropriate to the ICD revision indicated in FL 66 (Figure 109), describing the patient's diagnosis at the time of admission. This field is required when claim involves an inpatient admission.

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


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**




Instructions: Leave this field blank.

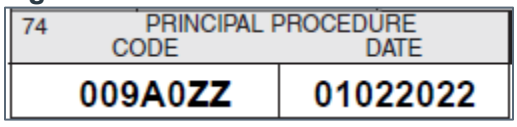
**Figure 116. FL 72a–c Situational: External Cause of Injury (ECI) Code and POA Indicator**


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**


Instructions: Leave this field blank.

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




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

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

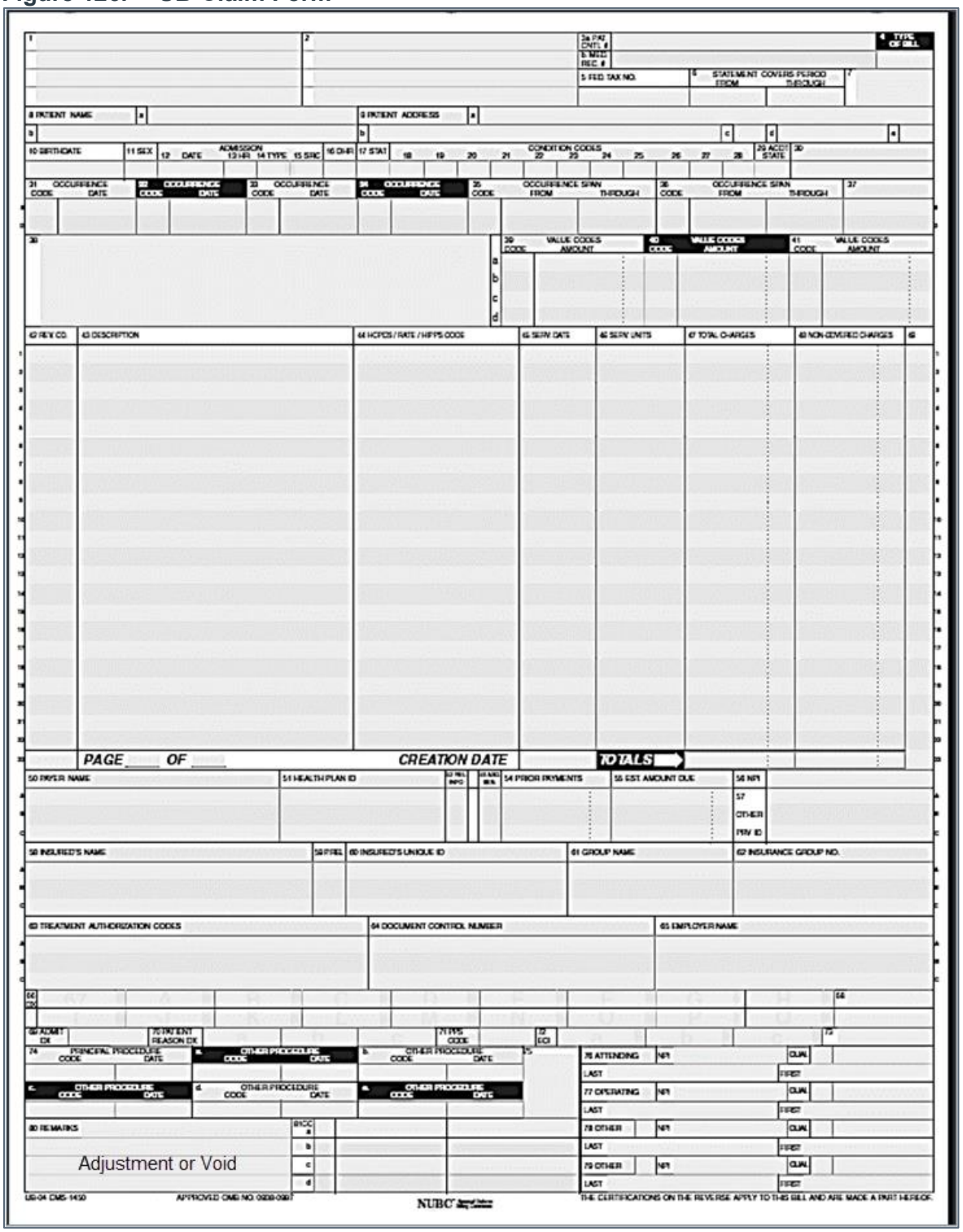
Instructions: Enter "Adjustment" or "Void" here.

**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**



## 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

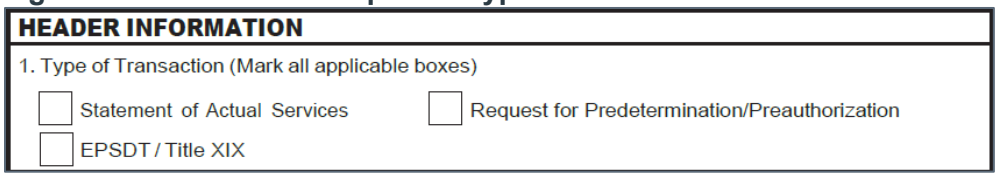
PO Box 23076

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**

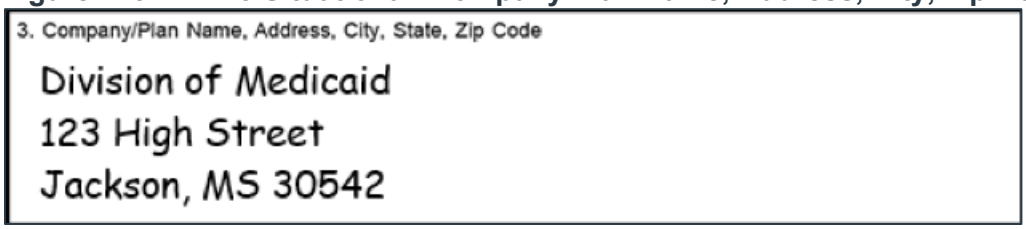



Instructions: Leave this field blank.

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

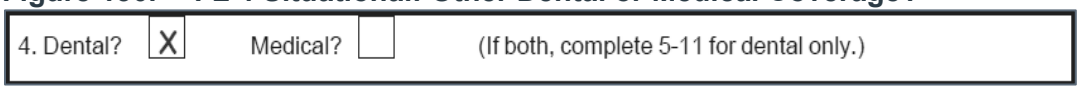
Instructions: Enter an authorization number without hyphens, dashes, spaces, etc. if entering a pre-authorized claim. Enter only one authorization per one claim form.

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



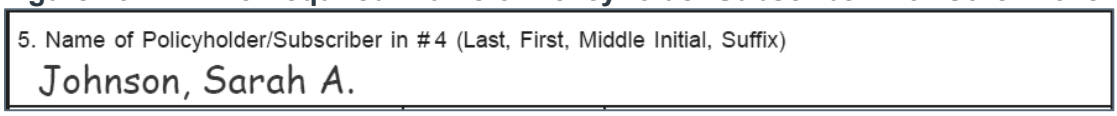

Instructions: Enter the name and address for the insurance company or dental benefit plan that is receiving the claim.

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



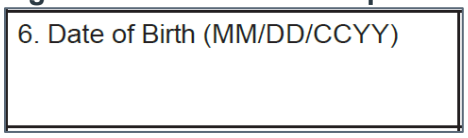

Instructions: Mark the box after “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, regardless of whether the dentist or the patient is submitting a claim to collect benefits under the other coverage. If either box is marked, complete FL 5-11.

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



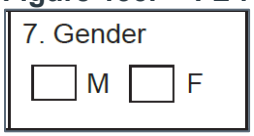

Instructions: Enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through spouse, domestic partner, or if a child, through a parent, the name of the person who has the other coverage is reported here.

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



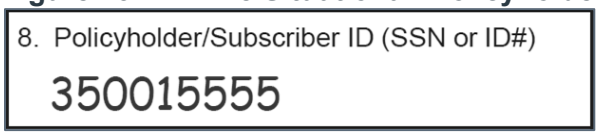

Instructions: Leave this field blank.

**Figure 133. FL 7 Not Required: Gender**



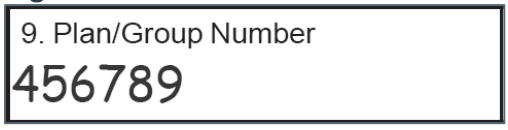

Instructions: Leave this field blank.

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



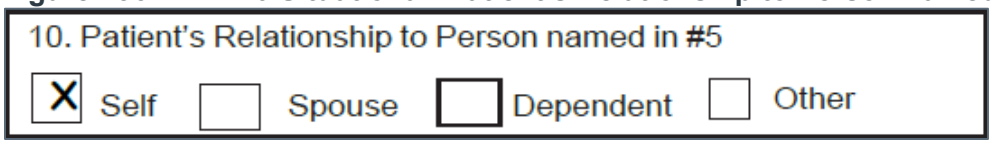

Instructions: Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in FL 5 (Figure 131), which is on the identification card.

**Figure 135. FL 9 Situational: Plan/Group Number**



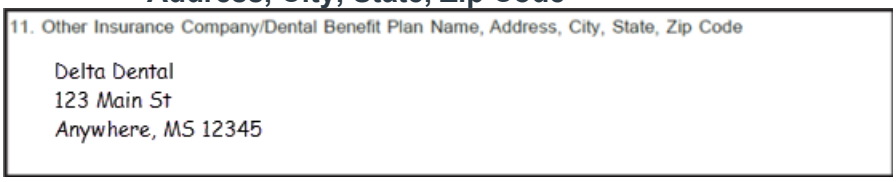

Instructions: Enter the group plan or policy number of the person identified in FL 5 (Figure 131).

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



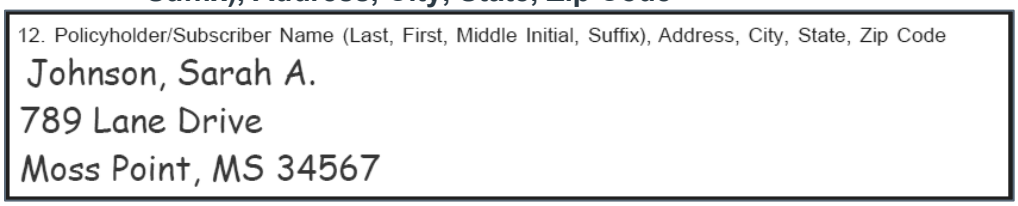

Instructions: Mark the box corresponding to the patient's relationship to the other insured name in FL 5 (Figure 131).

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



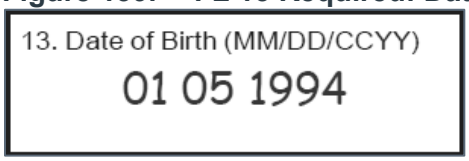

Instructions: Enter the complete information of the additional payer, benefit plan, or entity for the insured named in FL 5 (Figure 131).

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



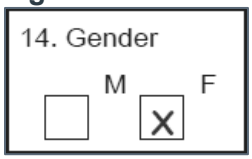

Instructions: Enter the complete name, address, and zip code of the Medicaid beneficiary receiving treatment.

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



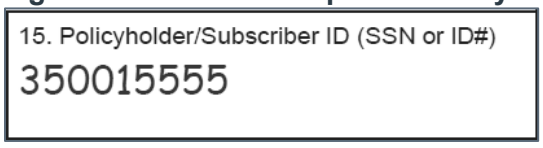

Instructions: Enter the Medicaid beneficiary's [from FL 12 (Figure 138)] date of birth with two digits for month and day and four digits for the year.

**Figure 140. FL 14 Required: Gender**



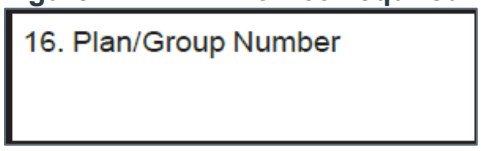

Instructions: Mark "M" for male, or "F" for female

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



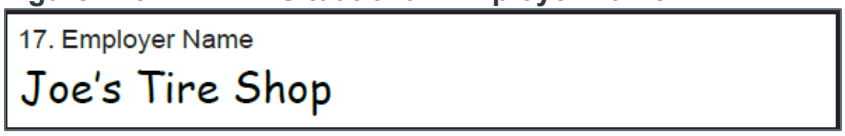

Instructions: Enter the full nine-digit identification number as listed on the policy holder's Medicaid card.

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



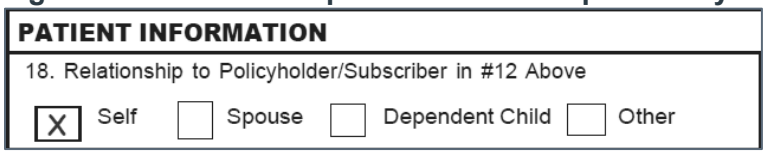

Instructions: Leave this field blank.

**Figure 143. FL 17 Situational: Employer Name**




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

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

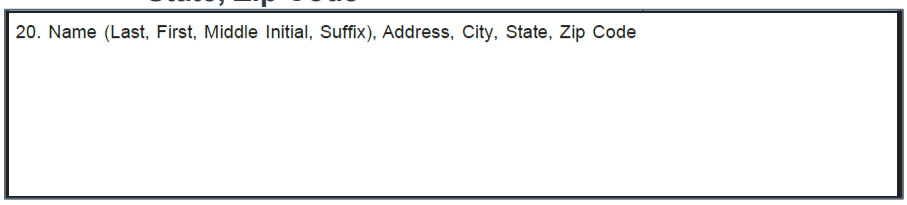



Instructions: Mark the relationship of the patient to the person in FL 12 (Figure 138) who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to FL 24 (Figure 150).

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

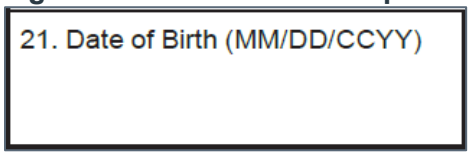

Instructions: Leave this field blank.

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



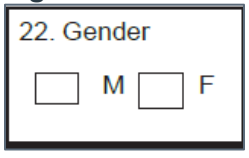

Instructions: Leave this field blank.

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



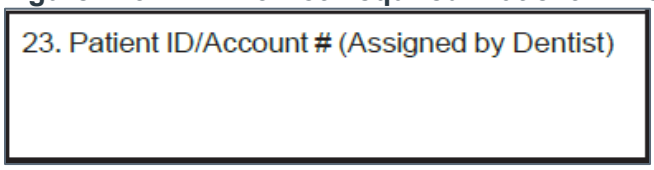

Instructions: Leave this field blank.

**Figure 148. FL 22 Not Required: Gender**



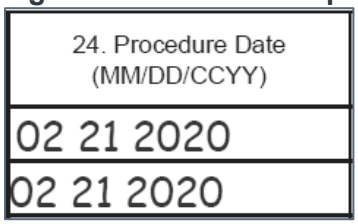

Instructions: Leave this field blank.

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



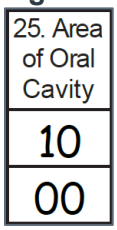

Instructions: Leave this field blank.

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




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.

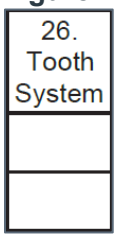
**Figure 151. FL 25 Situational: Area of Oral Cavity**




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

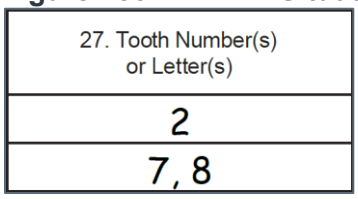
- 00 – Entire oral cavity
- 01 – Maxillary arch
- 02 – Mandibular arch
- 10 – Upper right quadrant
- 20 – Upper left quadrant
- 30 – Lower left quadrant
- 40 – Lower right quadrant

**Figure 152. FL 26 Not Required: Tooth System**




Instructions: Leave this field blank.

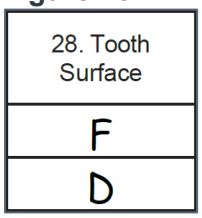
**Figure 153. FL 27 Situational: Tooth Number(s) or Letter(s)**




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

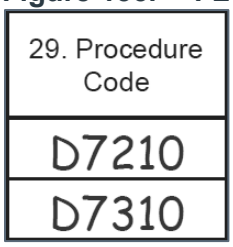
If the same procedure is performed on more than a single tooth on the same date of service, report each procedure code and tooth involved on separate lines on the claim form. Supernumerary teeth in the permanent dentition are identified by tooth numbers 51 through 82; for primary dentition, supernumerary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

**Figure 154. FL 28 Situational: Tooth Surface**



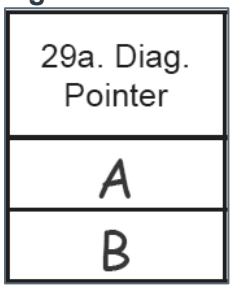

Instructions: Enter a tooth surface code.

**Figure 155. FL 29 Required: Procedure Code**




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)**




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 Add Signature or Signature on File (SOF) MM/DD/YYY

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**

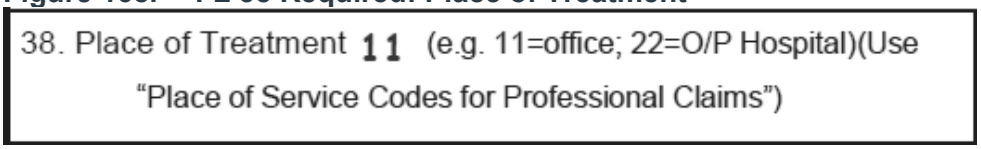
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____

Subscriber Signature Date

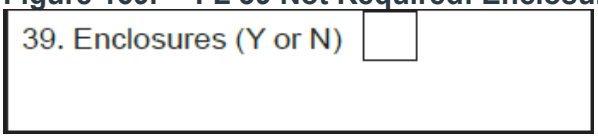
Instructions: Leave this field blank.

**Figure 168. FL 38 Required: Place of Treatment**



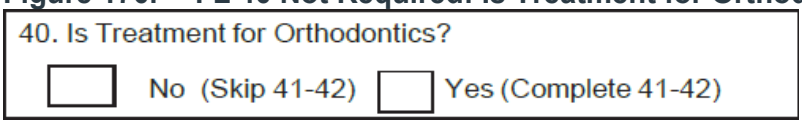

Instructions: Enter the two-digit Place of Service Code for Professional Claims; this is a HIPAA standard. A complete list of the Place of Service Codes is available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

**Figure 169. FL 39 Not Required: Enclosures**



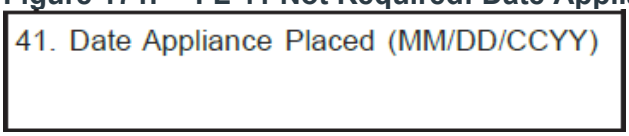

Instructions: Leave this field blank.

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



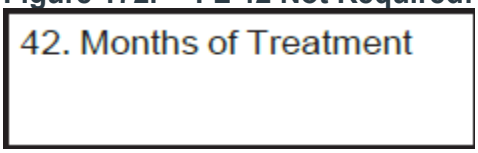

Instructions: Leave this field blank.

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



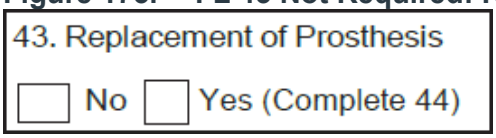

Instructions: Leave this field blank.

**Figure 172. FL 42 Not Required: Months of Treatment**



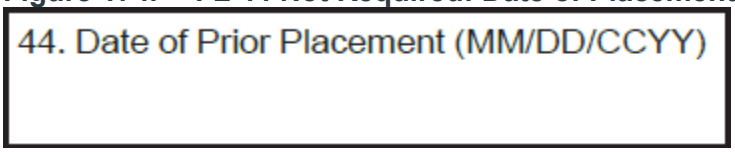

Instructions: Leave this field blank.

**Figure 173. FL 43 Not Required: Replacement of Prosthesis**



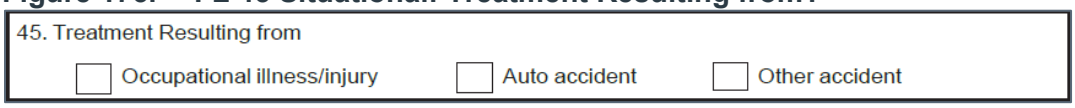

Instructions: Leave this field blank.

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



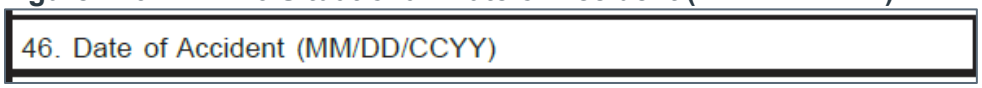

Instructions: Leave this field blank.

**Figure 175. FL 45 Situational: Treatment Resulting from?**



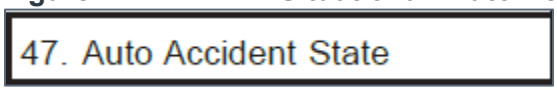

Instructions: If dental treatment is listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to FL 46 (Figure 176) and FL 47 (Figure 177). If the services you are providing are not the result of an accident, this field does not apply;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

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



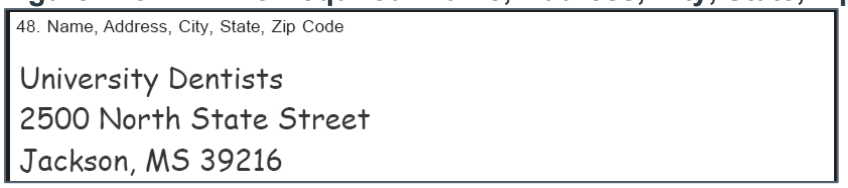

Instructions: Enter the date on which the accident noted in FL 45 (Figure 175) occurred. Otherwise, leave blank.

**Figure 177. FL 47 Situational: Auto Accident State**



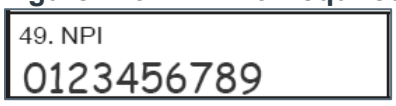

Instructions: Enter state where the auto accident occurred.

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



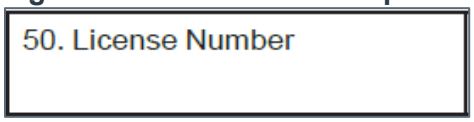

Instructions: Enter the name and complete address of the billing dentist or dental entity (group, corporation, etc.)

**Figure 179. FL 49 Required: NPI**




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**

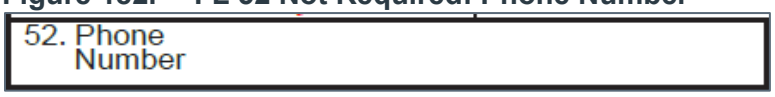



Instructions: Leave this field blank.

**Figure 181. FL 51 Not Required: SSN or TIN**

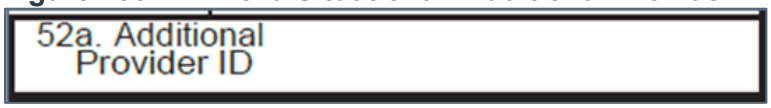

Instructions: Leave this field blank.

**Figure 182. FL 52 Not Required: Phone Number**



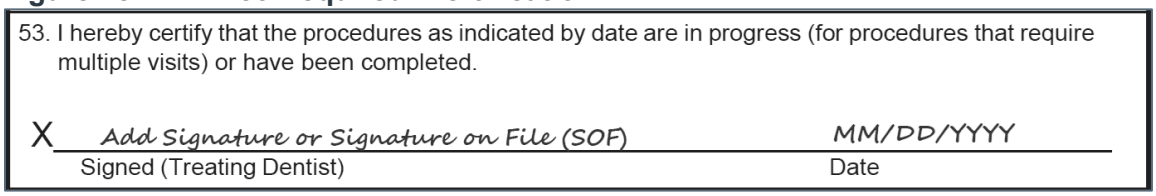

Instructions: Leave this field blank.

**Figure 183. FL 52a Situational: 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.

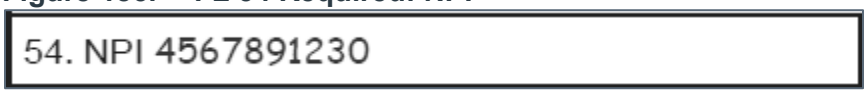
**Figure 184. FL 53 Required: Certification**




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.

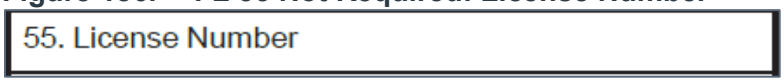
Note: Red ink should not be used for the signature.

**Figure 185. FL 54 Required: NPI**



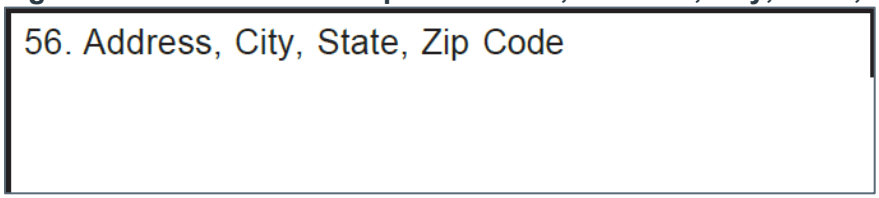

Instructions: Enter the appropriate ten-digit NPI number for the treating dentist. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.

**Figure 186. FL 55 Not Required: License Number**




Instructions: Leave this field blank.

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




Instructions: Leave this field blank.

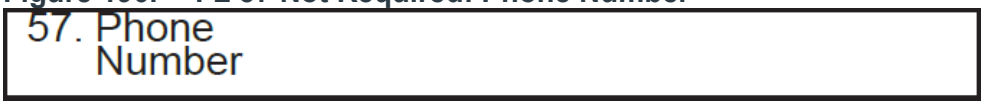
**Figure 188. FL 56a Required: Provider Specialty Code**


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**

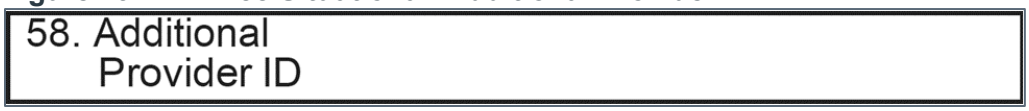
| Source | Description |
|---|---|
| Dentist | 122300000X |
| General Practice | 1223G0001X |
| Dental Public Health | 1223D0001X |
| Endodontics | 1223E0200X |
| Orthodontics | 1223X0400X |
| Pediatric Dentistry | 1223P0221X |
| Periodontics | 1223P0300X |
| Prosthodontics | 1223P0700X |
| Oral & Maxillofacial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

**Figure 190. FL 57 Not Required: Phone Number**



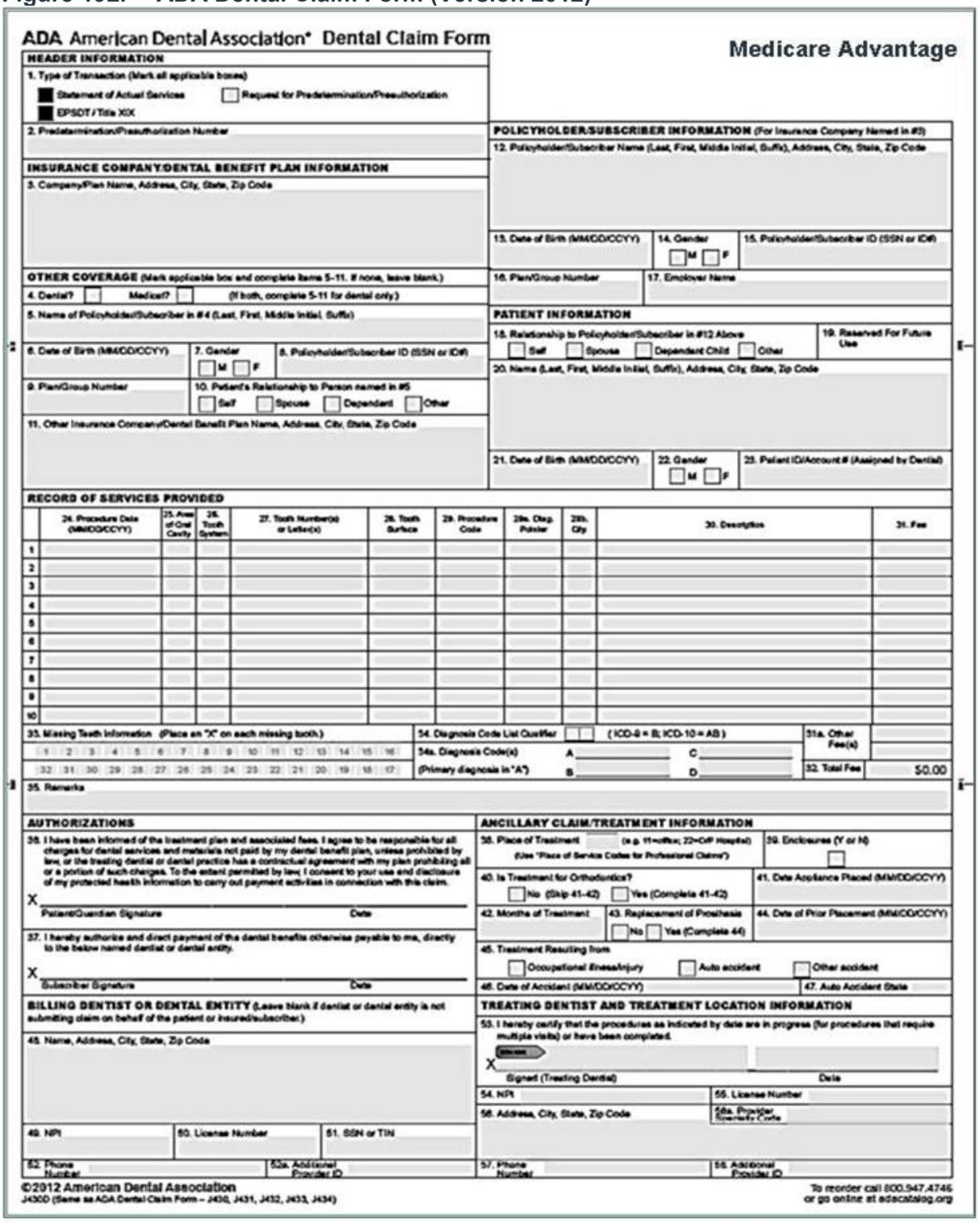

Instructions: Leave this field blank.

**Figure 191. FL 58 Situational: 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)
■ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
■ 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? ☐ Medical? ☐ (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/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ 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/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

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

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee $0.00

35. Remarks

AUTHORIZATIONS

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 _____
Patient/Guardian Signature Date

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

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist 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 | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=Off Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

| 45. Treatment Resulting from ☐ Occupational Illness/Injury | ☐ Auto accident | ☐ Other accident |
|---|---|---|
| 46. Date of Accident (MM/DD/CCYY) | | 47. Auto Accident State |

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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 _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Taxonomy Code

57. Phone Number | 58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

# 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.