



## Guidelines for Completing the Residential Claim Form

1. Bill only residential services on the Residential Claim Form.
2. To avoid denial of claims:
  - Use the correct form.
  - Complete and mail the form only after the last “To Date of Service”.
  - Verify all information is accurate and complete.
  - Enter all required information per instructions.
  - Type or write legibly.
  - Bill in whole units, not fractions.
  - Enter dollar amounts to include cents (e.g. 254.78 or 234.00).
3. If you believe inaccurate information is provided on the Community Care, Family Care Service Authorization, it is essential you contact the Provider Hotline at 1(866) 937-2783 prior to billing to discuss your concerns.

## Community Care Residential Claim Form Instructions

*Use the instructions below to complete your residential claim form. The numbers on the claim form match the numbers on the instruction sheet.*

### **Member Information Section**

- 1) **Member Last Name:** Enter the member’s last name as shown on the service authorization.
- 2) **Member First Name:** Enter the member’s first name as shown on the service authorization.
- 3) **Member’s Middle Initial:** Enter the member’s middle initial as shown on the service authorization.  
(If applicable).
- 4) **Member Date of Birth (DOB):** Enter member’s date of birth as shown on the service authorization.
- 5) **Member Account Number (Acct #):** Enter member’s account number as shown on the service authorization.

- 6) **Diagnosis Code:** The diagnosis code R6889 is listed by default.
- 7) **Admit Start Date:** Enter the date that the member began residing at your facility.
- 8) **Admission Source Code:** Enter the appropriate admission source code number. \_

- 9 – Information not available
- 6 – Transfer from another health care facility
- 5 – Transfer from SNF or ICF
- 8 – Admitted due to court order

9) **Discharge Status:**

**If the service is still continuing enter the code:**

- 30 – Still a patient (Resident)

**If the facility is no longer serving the Member, enter one of the following codes:**

- 01 – Discharge to home or self-care (routine discharge).
- 02 – Discharged/transferred to hospital or inpatient care
- 03 – Discharged/transferred to a skilled nursing facility.
- 21 – Discharged/transferred to court/law enforcement.
- 62 – Discharged/transferred to another type of institution for inpatient care.
- 07 – Left against medical advice or discontinued care.
- 20 – Expired/Died.

10) **Type of Bill:**

For Residential Services, enter one of the three type of bill codes below:

- 0862 – First Claim Submitted (First Claim submitted for a new resident)
- 0863 – Billing a continuing claim (Ongoing stay at a facility)
- 0867 – Corrected claim (Replacement of prior claim)

For Supportive Home Care Services, enter one of the three type of bill codes below:

- 0322 – First Claim Submitted (First Claim submitted for a new resident)
- 0323 – Billing a continuing claim (Continuing services and patient not discharged)
- 0327 – Corrected claim (Replacement of prior claim)

## **Provider Information Section**

- 11) **Provider Legal Name:** Enter the provider's name as shown on the service authorization
- 12) **Billing Address:** Enter the street address of the provider as shown on the service authorization.
- 13) **City/State/Zip Code:** Enter the City, State, and Zip Code of the Provider as shown on the service

authorization.

- 14) **Service Location Name:** Enter the name of the location where services are being provided.
- 15) **Service Location Address:** Enter the address of the location where services are being provided.
- 16) **City/State:** Enter the City, State of the location where services are being provided.
- 17) **Zip Code:** Enter the Zip Code of the location where services are being provided.
- 18) **Community Care (CCI) Provider ID:** Enter the provider number as shown on service authorization.
- 19) **Tax ID:** Enter the provider Tax ID as shown on your provider contract on the signature page.
- 20) **NPI Number:** Enter provider NPI number (if applicable)
- 21) **Service From Date:** Enter the first date of service for the period you are billing for.
- 22) **Service To Date:** Enter the last date of service for the period you are billing for.

**Important:**

- If service is being provided every day with no breaks, enter the last date of service for the period you are billing for on this claim.
- If there is a gap in services, you must bill on separate lines for each continuous period of service as “Dates of Service” must represent the actual dates the service was provided.  
(See Figure 1).
- If there are breaks in service, each “To Date” is the last date the member slept in you facility for that billing period.

**Figure 1**

21.) Service From Date	22.) Service To Date	23.) Authorization Number	24.) Revenue Code	25.) HCPCS Code	26.) Modifier	27.) Units
5/1/2023	5/20/2023	1234567	0241			20
5/25/2023	5/31/2023	1234567	0241			7

- 23) **Authorization Number:** Enter the authorization as shown on the service authorization.
- 24) **Revenue Code:** Enter the appropriate revenue code from the list below, your contract or your authorization.

Service	Revenue Code	Description
AFH 1-2 bed	120	Room & Board
	240	Care & Supervision
AFH 3-4 bed	130	Room & Board
	241	Care & Supervision
CBRF <8 beds	150	Room & Board
	242	Care & Supervision
CBRF > 8 beds	159	Room & Board
	243	Care & Supervision
RCAC	120	Room & Board
	670	Care & Supervision

25) **HCPCS (Procedure Code):** Applicable to RCAC only! Please include HCPCS (Procedure Code) T2031 when billing Revenue Code 0120 (Room & Board).

26) **Modifier:** Enter the modifier as shown on the service authorization if applicable.

27) **Units:** See Figures 2, 3, and 4 for examples.

**Figure 2 – One month billing for continuous stay.**

- If there is no break in service and you will continue to serve the member, enter the number of days that matches the range of dates beginning with the “Service From Date” and ending with the “Service To Date”.

21.) Service From Date	22.) Service To Date	23.) Authorization Number	24.) Revenue Code	25.) HCPCS Code	26.) Modifier	27.) Units
5/1/2023	5/31/2023	1234567	0241			31

**Figure 3 – One month billing with break in service and continuing services in the same month.**

- If there is a gap in service, you must bill on separate lines for a continuous period of service, as “Service Dates” must represent the actual dates the services were provided.
- For the first period of continuous service, enter the number of days that matches the range of dates beginning with the “Service From Date” to the “Service To Date” the Member slept at your facility. (See line 1 in Figure 3).
- For the second period of continuous service, enter the number of days that matches the range of dates beginning with the “From Date” and ending with the “To Date” (See Line 2 in Figure 3).

21.) Service From Date	22.) Service To Date	23.) Authorization Number	24.) Revenue Code	25.) HCPCS Code	26.) Modifier	27.) Units
5/1/2023	5/20/2023	1234567	0241			20
5/25/2023	5/31/2023	1234567	0241			7

**Figure 4 – One month billing with discharge.**

- If the member was discharged at the end of the stay, enter the number of days that matched the

dates beginning with the “Service From Date” to the day prior to the “Service To Date”. Do not include the discharge date as only the number of “nights” a member slept at the facility are to be paid.

21.) Service From Date	22.) Service To Date	23.) Authorization Number	24.) Revenue Code	25.) HCPCS Code	26.) Modifier	27.) Units	28.) Total
5/1/2023	5/31/2023	1234567	0241			30	

**28) Rate (Per Day):** Enter the rate per day or unit rate as shown on your provider contract.

**29) Total (Units x Rate):** Enter the total amount for each line.

**Note:** This will automatically calculate if you are completing this in Excel.

**30) Invoice Total:** Add all of the numbers in column 26 and enter the total billed amount to be paid using two decimal points (\$ 250.50). **This will automatically calculate if you are completing this in Excel.**

**31) Authorized Signature:** Signature of Individual authorizing the accuracy of the claim.

**32) Print Name:** Clearly print the name of the individual signing the claim.

**33) Date:** Enter the date the claim was signed by an authorized individual.

**34) Email Address:** Enter your email address.

**35) Phone Number:** Enter your phone number.

**36) Original DCN (Document Control Number):** If you are submitting a corrected claim please include the DCN number of the original claim that was submitted incorrectly. This number can be found on your remittance statement. If you are **not** submitting a corrected claim leave the corresponding box blank.

**Please Mail, Fax or E-Mail this form to:**

<p><b>MAIL:</b>  Community Care, Inc.  Attn: Claims Processing  P.O. Box 923  Brookfield, WI 53008-0923</p> <p><b>FAX:</b> (414) 385-6615  <b>EMAIL:</b> <a href="mailto:ClaimsProcessing@communitycareinc.org">ClaimsProcessing@communitycareinc.org</a></p>
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