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: Enter the diagnosis code or check the most appropriate code on the form.

V60.0 – Lack of Housing

V60.4 – No other Household Member Able to Render Care

V60.6 - Person Living in a Residential Institution

7a.) Admit Start Date: Enter the date that the member began residing at your facility.

7b.) Admission Source Code: Enter the appropriate admission source code.

9 Information not available

6 Transfer from another health care facility

5 Transfer from SNF or ICF

8 Admitted due to court order

8.) 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.

9.) Type of Bill: If you are entering a type of bill code for residential services please 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)

If you are entering a type of bill code for supportive home care services please 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)

0327-Corrected claim (replacement of prior claim)

Provider Information Section

10.) Provider Legal Name: Enter the provider's name as shown on the service authorization

11.) Billing Address: Enter the street address of the provider as shown on the service authorization.

12.) City/State/Zip Code: Enter the City, State, and Zip Code of the Provider as shown on the service authorization.

13.) Service Location Name: Enter the name of the location where services are being provided.

14.) Service Location Address: Enter the address of the location where services are being provided.

15a.) City/State: Enter the City, State of the location where services are being provided.

15b.) Zip Code: Enter the Zip Code of the location where services are being provided.

16.) Community Care Provider ID: Enter the provider number as shown on service authorization.

17.) Provider Tax ID: Enter the provider Tax ID as shown on your provider contract on the signature page.

18.) Provider NPI Number: Enter NPI number (if applicable)

19.) Service Dates:

From Date-Enter the first date of service for the period you are billing for on this claim.

To Date-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 service, 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

19.) Service Dates From Dates	To Dates	20.) Authorization Number	21.) Revenue Code	22.) HCPCS Code	23.) Modifier	24.) Units	25.) Rate	26.) Total
05/01/12	05/20/12							$ -
05/25/12	05/31/12							$ -
								$ -

20.) Authorization Number: Enter the authorization as shown on the service authorization.

21.) Revenue Code: Enter the appropriate revenue code from the list below, your contract or your authorization.

AFH 1-2 bed	0120	Room & Board
	0240	Care & Supervision
AFH 3-4 bed	0130	Room & Board
	0241	Care & Supervision
CBRF <8 beds	0150	Room & Board
	0242	Care & Supervision
CBRF > 8 beds	0159	Room & Board
	0243	Care & Supervision
RCAC	0120	Room & Board
	0670	Care & Supervision

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

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

24.) 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 be continuing to serve the member, enter the number of days that matches the range of dates beginning with the "From Date" and ending with the "To Date". See Figure 2 for an example.

Figure 2

19.) Service Dates From Dates	To Dates	20.) Authorization Number	21.) Revenue Code	22.) HCPCS Code	23.) Modifier	24.) Units	25.) Rate	26.) Total
05/01/12	05/31/12					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 "Dates of Service" must represent the actual dates the service was provided. For the first period of continuous service, enter the number of days that matches the range of dates beginning with the "From Date" to the "To Date". The "To Date" is the last date that the Member slept at you 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).

Figure 3

19.) Service Dates From Dates	To Dates	20.) Authorization Number	21.) Revenue Code	22.) HCPCS Code	23.) Modifier	24.) Units	25.) Rate	26.) Total
05/01/12	05/20/12							$ -
05/25/12	05/31/12							$ -
								$ -

Figure 4- One month billing with discharge.

If the member was discharged, enter the number of days that matched the dates beginning with the "From Date" to the "To Date". The "To Date" is the last date the Member slept at your facility.

Figure 4

19.) Service Dates From Dates	To Dates	20.) Authorization Number	21.) Revenue Code	22.) HCPCS Code	23.) Modifier	24.) Units	25.) Rate	26.) Total
05/01/12	05/20/12							$ -
05/25/12	05/31/12							$ -
								$ -

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

26.) **Total (Units x Rate):** Enter the total amount for each line. **This will automatically calculate if you are completing this in Excel.**

27.) **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.**

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

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

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

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

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

33.) **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 or Fax your completed Form to:

COMMUNITY CARE, INC.
Attn: Claims Processing
P.O. Box 923
Brookfield , WI 53008-0923
FAX- (414)-385-6615