Cook Children's Health Plan

## Tips for Submitting Paper Claims

Cook Children's Health Plan is taking steps to improve the speed and accuracy in processing paper claims. While we highly encourage electronic claim submissions, should you find that you can only submit a claim on paper, please follow these tips:

### Claims With or Without Attachments

- Use original claim forms. Do not use copies of claim forms
- Do not fold claim forms
- Print claim data within defined boxes on the claim form
- Handwritten claim forms cannot be accepted and will be returned
- Use all capital letters
- Print using a 12-point font. Do not use fonts smaller or larger than 12-point. Do not use proportional fonts, such as Arial or Times New Roman.
- Do not use dashes or slashes in date fields
- Use paper clips on claims or appeals if they include attachments. Do not use glue, tape, or staples.
- Place the claim form on top when sending new claims followed by any other attachments
- One prior authorization number per claim; block 23 for CMS-1500 claim forms
- Claims must contain the billing provider's complete name, address, and provider identifier. Claims missing this information cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.
- All required information must be included in the appropriate block. Information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.
- Providers should keep a copy of the documentation they send by mail. We strongly recommend sending claims by certified mail with a return receipt to support proof of timely filing. This is particularly important if it is necessary to prove that claims were received by the health plan within the the 95-day filing deadline.

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**Multipage Claim Forms**

- The CMS-1500 paper claim form is designed to list 6 items in Block 24. If more than six line items are billed on a paper claim, a provider may attach additional forms (pages) totaling no more than 28 line items.
- Number the pages when sending attachments or multiple page claims for the same Member (e.g., 1 of 2, 2 of 2)
- Do not total the billed amount on each claim form when submitting multi-page claims for the same Member. Block 28 should be left blank or indicate "CONTINUE". The combined total charges for all pages should be listed on the last page in Block 28.

**Required provider information:**

- "ZZ" ID Qualifier (24I-Shaded)
- Taxonomy Code (24J-Shaded)
- National Provider Identifier (NPI) of Rendering Provider (24J-Unshaded)
- Billing Provider NPI (33a)
- Billing Provider Taxonomy Code (33b)
- Referring, Ordering or Supervising Provider Name and NPI (17a & 17b), if applicable
    - If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19
    - The following qualifiers must be used:
        - DN = Referring Provider
        - DK = Ordering Provider
        - DQ = Supervising Provider

If you do not have an NPI, place your Atypical Provider ID (API)/LTSS# in Box 33b.

**National Drug Code**

The National Drug Code (NDC) is an eleven (11) digit number on the package or container from which the medication is administered. When submitting a HCPC code that is represented by a NDC, you must also submit the NDC code, Quantity and Description.

A NDC is composed of three sets of numbers:

- The first five numbers are assigned by the Food and Drug Administration (FDA) and identifies the labeler, that is, the manufacturer, repackager, or distributer of the drug
- The middle four numbers represent the product code. It identifies the specific strength, dosage form, i.e. capsule, tablet, liquid, etc., and the formulation of a drug for a specific manufacturer
- The last two numbers are the package code and identifies package sizes and types

The National Drug Unit of Measure must be included. The submitted Unit of Measure should reflect the volume measurement administered. Refer to the NDC Package Measure column on the Texas National Drug Code (NDC)-to-Healthcare Common Procedure Coding System (HCPCS) Crosswalk.

Valid unit of measurement codes – unit quantities are required:

- F2—International unit
- GR—Gram
- ME—Milligram
- ML—Milliliter
- UN—Unit

NDC qualifier of “N4” must be entered before the NDC on claims.

CMS-1500:
Field 24 A: “N4” plus 11 digit NDC code
Field 24 D: (shaded) should have Quantity
Field 24 G: (shaded) should have Unit of Measure

CMS-1450:
“N4” plus 11 digit NDC code, Unit of Measure and Quantity

*For more information, please refer to the most current Texas Medicaid Provider Procedures Manual.*

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