

RESIDENTIAL FACILITY CLAIM FORM

Mail Claims To:

Independent Care Health Plan
P.O. Box 224255
Dallas, TX 75222-4255
1-877-333-6820



*Required fields denoted with an asterisk **

* Member/Client Name: * Type of Bill:
(Refer to Key)

* Member ID Number: DOB: Gender:

Patient Account Number:

* Billing Provider Name: * Tax ID Number:

* Billing/Remit Address:

* City, State & Zip: Service Request Number/s (authorization):

* Rendering Facility Name: * Rendering Facility Address:

* City, State & Zip:

* Statement Period From: * Statement Period To:
(mm/dd/yyyy) (mm/dd/yyyy)

* Admission Date: * Discharge Status:
(Date of original admission mm/dd/yyyy) (Refer to Key)

*Diagnosis Code:
(Refer to key)

HIPAA Service Code <small>(5 digits)</small>	*Revenue Code <small>(4 digits)</small>	* Modifier	* Billing Period From Date <small>(mm/dd/yyyy)</small>	* Billing Period To Date <small>(mm/dd/yyyy)</small>	* Number of Days/Units	* Rate Per Day/Unit	* Total Billed
<small>(Refer to letter authorizing services)</small>						Grand Total	
Signature*						Date	

RESIDENTIAL FACILITY CLAIM KEY



In order to process your claims accurately and timely, please refer to the information below when completing your claim forms. Incomplete claims may result in a delay in processing. Fields marked "*" are mandatory for processing.

Field	What To Enter
Member/Client Name *	Name (first, middle initial and last) of iCare client
Member ID Number *	Member's Medicaid Number (located on the service request summary created by the Care Manager)
Patient Account Number	Provider's own internal account number for the member
DOB	Member's date of birth (mm/dd/yyyy)
Gender	Male or female
Type of Bill (choose one)*	861 - Respite services
	862 - First claim for client
	863 - Continuous claim for an ongoing stay
	864 - Last claim for client
Billing Provider Name *	Name of billing facility
Billing/Remit Address *	Address where payment should be sent
City, State & Zip *	City, state and zip code of billing provider
Tax ID Number *	Federal Tax ID number or social security number under which you bill
Service Request Number	Number on the summary created by the Care Manager which authorizes services
Rendering Facility Name*	Name of facility where services were rendered
Rendering Facility Address*	Address of facility where services were rendered
City, State & Zip*	City, state and zip code of facility where services were rendered
Statement Period From *	First date of billing period; must be in mm/dd/yyyy format.
Statement Period To *	Last date of billing period; must be in mm/dd/yyyy format.
Admission Date	Original admission date to facility or residence; must be in mm/dd/yyyy format.
Discharge Status (choose one)*	01 - Discharge to home or self-care (routine discharge)
	02 - Discharged or transferred to hospital or inpatient care
	03 - Discharged or transferred to a skilled nursing facility
	04 - Discharged or transferred to an intermediate care facility
	05 - Discharged or transferred to another type of institution for inpatient care
	07 - Left against medical advice or discontinued care
	20 - Expired/died
30 - Still a patient (ongoing stay)	
Diagnosis Code*Effective 10/1/2015	Diagnosis of member use default to Z02.9 if unknown for Date of Service 10/1/2015
HIPAA Service Code	Only required if included in your authorization
Revenue Code *	Revenue code provided by iCare which can be located on the letter that authorizes services. It must be
Modifier * (if applicable)	2-digit/character code that provides specific information relating to HIPAA or revenue code (if applicable); located on the service request summary under the procedure name.
Billing Period From Date *	Date services for which you are billing <u>began</u> ; must be in mm/dd/yyyy format.
Billing Period To Date *	Date services for which you are billing <u>ended</u> ; must be in mm/dd/yyyy format.
Number of Days/Units *	Number of units or days billed for the specific code listed on the service line; MUST
Rate per Day/Unit Amt. *	Dollar amount/rate per day or unit.
Total Billed Amount *	Billed amount for services on that line
Grand Total *	Total of all service lines
Signature*	The Provider Signature indicates responsibility for the implementation of the MCP as described in the Service Authorization