Rhode Island Medicaid
837 Institutional – Home Health Claim Form

This document is a field –by –field instructional help sheet. The fields are listed in a right to left format as they appear in the Provider Electronic Solution Software. Examples of the values needed in order to process the claim are given. Those fields with "Not Required" listed as a value, are present on the claim per HIPAA regulations and are not needed in order to process the claim. This software will not allow you to save a claim with a required field missing, however this does not guarantee that your claim will pay, just that the basic information is present. Auto populated fields have the valid value already present and do not need to be entered. **Represents a list that must be created in order to process the claims. Please see additional documentation on how to create your list.

Please use the TAB button from your keyboard to navigate throughout the software.

Header 1

FIELD	VALUE
Type of Bill	Select the appropriate bill type for the claim.
Provider ID **	Select your 10 digit National Provider Identifier number from the drop down list.
Taxonomy Code	This will auto populate using the TAB button after selecting the NPI.
Last/Org Name	This will auto populate using the TAB button after selecting the NPI.
First Name	This will auto populate using the TAB button after selecting the NPI.
Client ID **	This is the MID of the client you are billing services for. Choose from the drop down list.
Account Number	This will auto populate using the TAB button when the client number is selected from the client list.
Last Name	This will auto populate using the TAB button when the client number is selected from the client list.
First Name	This will auto populate using the TAB button when the client number is selected from the client list.
MI	**NOT REQUIRED**
From DOS	Select the begin date of service for all details submitted for this claim
To DOS	Select the end date of service for all details submitted for on this claim
Signature on File	**Auto – Populated to Y = Yes**
Patient Status	**Choose a valid value from the drop down list.**
Medical Record Number	**NOT REQUIRED**
Benefits Assignment	**Auto – Populated to Y = Yes**
Release of Medical Data	**Auto – Populated to Y = Yes**
Report Type Code	**NOT REQUIRED**
Report Transmission Code	**NOT REQUIRED**

Header 2

FIELD	VALUE
Qualifier	Select appropriate Diagnosis Qualifier either ICD-9 or ICD-10
Diagnosis Code: Primary	Enter the ICD-9 or ICD-10 code describing the conditions for which you are treating the client i.e. 010019 Pre-existing essential hypertension complicating pregnancy, unspecified trimester. These can be acquired from the clients Primary Care Physician or your medical records and are based on date of service.
E -Code	**NOT REQUIRED.**
Attending Provider** SSN/Tax ID	The information will be auto populated when the NPI is selected from the other provider list and then you hit the tab button on your keyboard
Taxonomy Code	If NPI is selected from provider list this will auto populate as well.
Last/Org Name	Will be auto populated when the NPI number is selected from the other provider list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the NPI number is selected from the other provider list and then you hit the tab button on your keyboard
MI	**NOT REQUIRED**
Referring Provider** SSN/Tax ID	The information will be auto populated when the NPI is selected from the other provider list and then you hit the tab button on your keyboard
Last/Org Name	Will be auto populated when the NPI number is selected from the other provider list and then you hit the tab button on your keyboard
First Name	Will be auto populated when the NPI number is selected from the other provider list and then you hit the tab button on your keyboard
Admission Type	**REQUIRED.** Select any value that applies. If information is not available to you for this claim you may select 9 (information not available).
Other Insurance Ind.	**THIS IS AUTO POPULATED TO N – NO.** This may be changed to Y = yes if billing Medical Assistance as a secondary or co - insurance * please see "Billing Other Insurance" directions for further instructions when billing secondary claims.

SRV 1

FIELD	VALUE
From DOS	Select the beginning date of service for the period of time you are submitting for on this claim. Should be within the span date used on the header of the claim.
To DOS	Select the end date of service for the period of time you are submitting for on this claim. Should be within the span date used on the header of the claim.
Revenue Code	Select the appropriate Revenue code. Can be the same as Medicare
Billed Amount	Enter charges for procedure
Units	Select the total units you are billing for
Basic Unit of Measure	**Auto populated to UN = Units**
Procedure	Select the procedure code you are billing for.
Modifiers	Use if applicable
Line Item Control NBR	**NOT REQUIRED**