Waiver Services – Waiver/Rehab Claim Form Instructions

FIELD NAME	INSTRUCTIONS
Recipient Number	Enter the recipient's Medicaid identification number
Patient Name	Enter 5 characters of the last and 2 characters of the first name of the recipient who received services from the provider
Primary Diagnosis	Enter the diagnosis code for the primary illness or injury for which the recipient was treated. Select an ICD-9 or ICD-10 diagnosis code depending on date of service.
Secondary Diagnosis	Enter the diagnosis code for the secondary illness or injury (if any) for which the recipient was treated. Select an ICD-9 or ICD-10 diagnosis code depending on date of service. If none, leave blank.
Procedure Code	Enter the five character HCPCS code that describes the procedure performed.
Modifiers	Enter up to three modifiers that apply to the HCPCS procedure code in Box #5.
Level of Care (LOC)	Leave blank.
Patient Liability	Enter the amount the patient must pay for each procedure.
From Date	Enter the beginning month, day or year of the service being billed.
Thru Date	Enter the last date (day) of the service billed.
OI Indicator	Enter "Y" if the service being billed is covered by any other insurance, including Medicare. Enter "N" if it is not.
OI Code	Enter the three digit carrier code of the other insurance.
OI Amount	Enter the dollar amount that all other insurance carriers have paid toward the services rendered on this claim line.
Units	Enter the number of units billed for the service on each claim line.
Rate	Enter the amount charged per unit of service on each claim line.
Charge	Enter the total amount charged for the service on each claim line (rate times units)

Total OI	Enter the total amount paid by all other insurance listed (in column 15) on all claim lines.
Total Charge	Enter the total amount of all the charges listed (in column 16) on all the claim lines.
Billing Provider Number	Enter the NPI of the provider submitting the claim. Be sure this information is on the correct line or claim will not process.
Billing Provider Name	Enter the name of the provider submitting the claim. Be sure this information is on the correct line or claim will not process.
Billing Provider Taxonomy	Enter the billing provider taxonomy. Be sure this information is on the correct line or claim will not process.
Performing Provider Number	Enter the NPI of the provider who performed the service.
Performing Provider Name	Enter the first and last names of the provider who actually performed the service. (Leave blank if the same as field #1)
Performing Provider Taxonomy	Enter the taxonomy for the provider who performed the service.
ICD-IND	Enter 9 for ICD-9 diagnosis codes and 0 for ICD-10 diagnosis codes. The correct code set is determined by date of service. • Note: The indicator entered must align with the diagnosis code entered in boxes 3 and 4. • ICD-9 and ICD-10 codes may not be mixed on the same claim form.
Certification	After reading the certification statement, the provider must sign and date the form. The signature must be an original signature and not a stamp.