RESIDENTIAL FACILITY CLAIM FORM

Mail Claims To:

Independent Health Care Health Plan
P.O. Box 670
Glen Burnie, MD 21060-0670
1-877-333-6820

INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

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:** MM/DD/YYYY ***Statement Period To:** MM/DD/YYYY

***Admission Date:** (Date of original admission MM/DD/YYYY) **Discharge Status:** Refer to Key

***Diagnosis Code:** Refer to Key

FOR CORRECTED CLAIMS:
Original Ref. No.

HIPPA Service Code (5 Digits	*Revenue Code (4 Digits)	*Modifer	Modifer	Modifer	Modifer	*Billing Period From Date (mm/dd/yy)	*Billing Period To Date (mm/dd/yy)	*Number of Days/ Units	*Rate Per Day/ Unit	*Total Billed
(Refer to letter authorizing services)								Grand Total		
Signature*									Date	

RESIDENTIAL FACILITY CLAIM KEY

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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)*	837 - Original Claim No.
	861 - Respite services
	862 - First claim for client
	863 - Continuous claim for an ongoing stay
	864 - Last claim for client
	867 - Replacement of a prior claim (corrected claim)
Billing Provider Name *	
Billing/Remit Address *	
City, State & Zip *	
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 (MUST be **4 digits**)
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 began; must be in mm/dd/yyyy format.
Billing Period To Date *	Date services for which you are billing ended; must be in mm/dd/yyyy format.
Number of Days/Units *	Quantity or unit of measure (MUST BE **WHOLE** UNITS)
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