

# Commonwealth of Virginia Fiscal Agent and Provider Enrollment Services

## Mailroom and Document Control Operational Procedures Manual

February 2, 2016  
Version 29.0

Other company trademarks are also acknowledged.

## Revision History

Version Number	Date	Description	Author
1.0	1/29/2010	Initial draft of procedure manual	Paul Thomas
2.0	3/16/2010	Updates from DMAS Comments Grid	Paul Thomas
3.0	11/15/2010	Quarterly Updates	Adam Patterson/Shelia Smith
4.0	12/14/2010	Updates from DMAS Comments Grid	Adam Patterson/Shelia Smith
5.0	3/18/2011	Quarterly Updates	Shelia Smith
6.0	4/1/2011	Updates from DMAS Comments Grid	Shelia Smith
7.0	6/20/2011	Quarterly Updates	Shelia Smith
8.0	10/12/11	Quarterly Updates	Shelia Smith
9.0	11/9/11	Updates from DMAS Comments Grid	Shelia Smith
10.0	1/27/12	Quarterly Updates	Shelia Smith
11.0	3/1/2012	Updates from DMAS Comments Grid	Shelia Smith
12.0	3/14/12	Updates from DMAS Comments Grid	Shelia Smith
13.0	4/16/12	Quarterly Updates	Shelia Smith
14.0	5/29/12	Updates from DMAS Comments Grid	Shelia Smith
15.0	7/13/12	Quarterly Updates	Shelia Smith
16.0	9/7/12	Updates from DMAS Comment Grid	Shelia Smith
17.0	10/15/12	No Quarterly Updates	Shelia Smith
18.0	1/23/13	Quarterly Updates	Shelia Smith
19.0	4/12/13	Quarterly Updates	Shelia Smith
20.0	6/14/13	Quarterly Updates	Shelia Smith
21.0.	7/9/13	Updates from DMAS Comments Grid	Shelia Smith
22.0	10/18/13	Quarterly Updates	Shelia Smith
23	1/15/14	Quarterly Updates	Shelia Smith
24.0	4/15/14	Quarterly Updates	Shelia Smith

<b>Version Number</b>	<b>Date</b>	<b>Description</b>	<b>Author</b>
25.0	6/30/14	Quarterly Updates	Shelia Smith
26.0	10/16/14	Quarterly Updates	Shelia Smith
27.0	02/06/15	Quarterly Updates	Shelia Smith
28.0	5/1/15	Quarterly Updates	Shelia Smith
29.0	2/2/16	Quarterly Updates	Shelia Smith

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# 1. Introduction

## 1.1. Purpose

██████████ ██████████ is the Fiscal Agent for the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) and serves as a liaison between DMAS and the provider community. ██████████ Mailroom and Document Control Units are responsible for:

- Courier Services
- Incoming and Outgoing Mail
- Returned Mail Distribution
- Returned Member ID Cards
- Document Preparation – Sorting, Prescreening and Batching
- Scanning
- Indexing Images
- Document Retention/Storage/Destruction

This manual will provide the detailed steps for performing the Mailroom and Document Control functions.

## 1.2. Department Overview

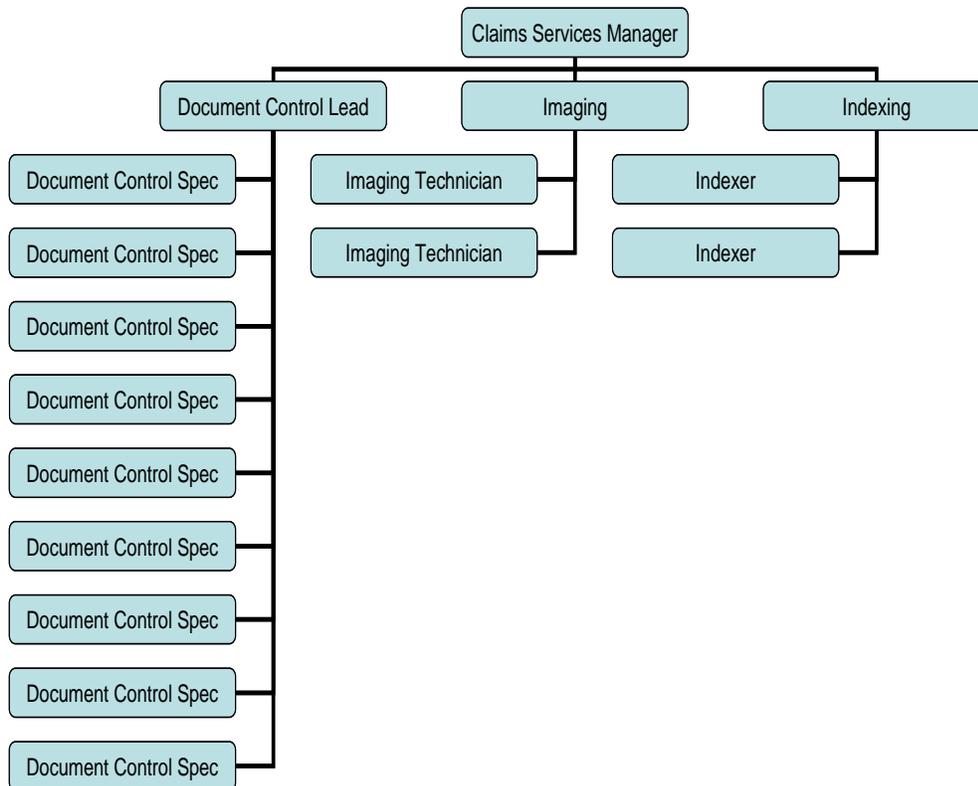
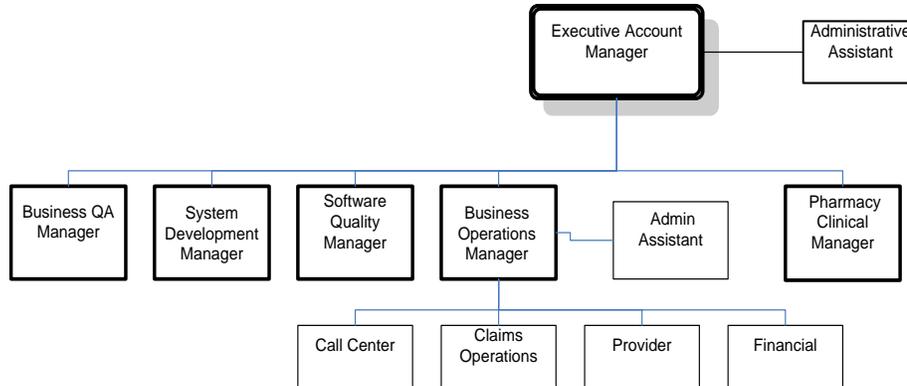
### Objectives and Tasks

The Mailroom and Document Control Units report to the Claims Services Manager. The Units primary objectives are to receive, sort, screen, batch and scan payment and non-payment documents received for the Department of Medical Assistance Services Medicaid Programs. In addition the unit is responsible for the accurate distribution of incoming documents to the appropriate processing units and the accurate assignment of index property values for image storage and retrieval through the Enterprise Content Management System (ECM).

In addition, there are quality initiatives in place to monitor the correct processing of claims and correct any issues that arise in the course of daily operations. Some of these quality initiatives include sampling of claims on a consistent basis to ensure proper entry and processing, as well as re-training. The Quality Assurance Procedures Manual can be referenced for further detail on quality initiatives.

### Staffing Overview

The Mailroom and Document Control Units report into the Claims Services Manager. The Mailroom includes Document Control Specialists, Imaging Technicians and Indexers. The Claims Services Manager is responsible for overseeing the daily operations of the Units and reports to the Business Operations Manager. Below is the organizational chart for Claims Services followed by descriptions for the Mailroom and Document Control positions:



## 1.2.1. Claims Operations Manager

The Claim Services Manager is responsible for the functions performed in the Mailroom and Document Control Units. The Claims Services Manager is responsible for the day to day management of the front line staff, volumes, quality of services delivered and the performance of the Units in accordance with contractual service levels.

Additional core responsibilities include:

- Performs side-by-side performance observations on a regular basis for all direct reports to measure quality and efficiency of work performed.
- Manages the relationship and performance of our [REDACTED] contracted courier service and [REDACTED] data entry.
- Creates work plans, procedure manuals, and other required materials to ensure department objectives are met.
- Provides support to staff for questions and handles escalated situations quickly and efficiently.
- Meets with Managers of other functional areas to understand the effectiveness of staff in delivering the support services for their areas of responsibility.
- Develops staff through daily interactions, coaching and on-going performance evaluations.
- Responsible for attaining daily, weekly and monthly performance levels. Leverages business intelligence to actively contribute to trending and root cause analysis efforts.
- Educates staff on department procedures and builds subject matter expert (SME) level knowledge for each job function.
- Responsible for in-depth knowledge of the tools and services that support their Units: Postal Services, Courier Services, Kodak Scanners, Datacap Software, FileNet Enterprise Content Management (ECM) System, FileNet Workflow, etc.

#### 1.2.1.1. Document Control Specialist

The Document Control Specialists are responsible for screening incoming mail received through the United States Postal Service (USPS) or Interoffice mail and distributing to appropriate operational units. The screening process includes opening, sorting, screening, cleansing, and batching documents in preparation for imaging; sorting and batching outgoing interoffice mail. They also meter outgoing USPS mail and oversee the retention and destruction of imaged documents. Other responsibilities include:

- Logs certified mail received from the post office.
- Screens incoming mail receipts to determine routing for processing.
- Sorts incoming documents into the required batches.
- Completes batch cover sheets to ensure the correct information is included.
- Screens documents to validated required documentation information.
- Identifies missing information and returns documents to the provider.
- Batch documents by scan job type and prepares for imaging.
- Processes returned member ID cards in accordance to department procedures.
- Escalates required situations appropriately and in accordance with department guidelines.
- Notifies management of system issues or other trends identified.
- Manages their adherence to scheduled hours, quality, efficiency of work, and on-going knowledge development.

#### 1.2.1.2. Image Technician

The Image Technicians are responsible for scanning claims and non-claim documents for delivery of images to the Image Indexing and Claims data capture processes. Imaged documents are filed in preparation for retention.

Other responsibilities include:

- Prepares the scanners for daily processing.
- Sets the correct job types for each batch scanned.
- Scans documents in accordance with department guidelines.
- Monitors image quality as documents are being scanned.
- Re-scans documents as image quality issues are identified.
- Escalates required situations appropriately and in accordance with department guidelines.
- Notifies management of system issues or other trends identified.
- Manages their adherence to scheduled hours, quality, efficiency of work, and on-going knowledge development.

### 1.2.1.3. Indexer

The Indexers are responsible for entering the index properties of images in preparation for image archive in the Enterprise Content Manager (ECM) with associated document properties that allow search and retrieval of images.

- Data enters the correct index property values for each document type.
- Separates incoming faxes and assigns the correct document type.
- Monitors image quality.
- Supports Document Control and Imaging processes.
- Escalates required situations appropriately and in accordance with department guidelines.
- Notifies management of system issues or other trends identified.
- Manages their adherence to scheduled hours, quality, efficiency of work, and on-going knowledge development.

# 1.3. Service Level Requirements

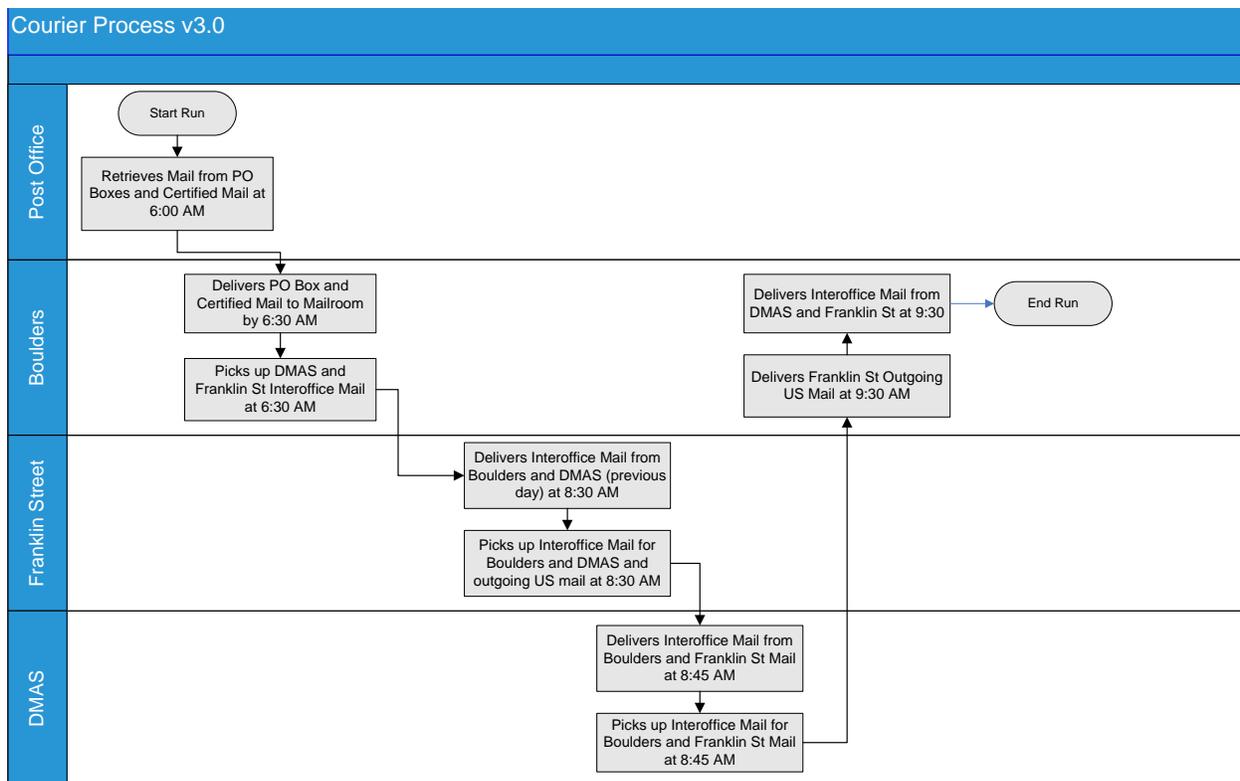
Service Level Agreements – Mailroom and Document Control	
Description	Performance Target
Return all paper payment requests with missing key fields.	Returned ≤ 48 hours after receipt
Image and profile incoming provider documents	< 2 business days from receipt
Provide hardcopy request for payment documentation.	< 2 working days, or upon DMAS request
Process all claims through adjudication cycle.	≤ 72 hours upon receipt

## 2. Courier Services

██████████ utilizes a contracted vendor for courier services. The courier picks up incoming mail from multiple post office boxes and certified mail from the post office customer service window. Mail is also picked up and delivered at DMAS and ██████████ locations. The courier picks up outgoing US mail and interoffice mail from the ██████████ for delivery to the post office, DMAS and ██████████. The following workflow outlines the courier's delivery route.

### 2.1. Courier Services Workflow

This diagram presents a graphic depiction of the document preparation, screening, and scanning processes.



## 2.2. Post Office Box Listing and Contents

Post Office Box Location	Post Office Box Address	Contents
Brook Road Facility 1801 Brook Rd Richmond, VA 23232 (804) 775-6133	Department of Medical Assistance Services PO Box 27444 Richmond, VA 23261-7444	CMS-1500 Payment Requests
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 27443 Richmond, VA 23261-7443	UB-04 Payment Requests
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 27441 Richmond, VA 232261-7441	Crossover Claims/DMAS 30 R5/06
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 27445 Richmond, VA 23261-7445	Pharmacy Claims
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 85083 Richmond, VA 23285-5083	Adult Care Resident Assessments (ACR)
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 27446 Richmond, VA 23261-7446	Requested Documentation (ER Records, etc.)
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 26803 Richmond, VA 23261-6803	Provider Enrollment Services (PES)
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	Department of Medical Assistance Services PO Box 26228 Richmond, VA 23261-6228	Administrative (Returned Mail)
Brook Road Facility 1801 Brook Rd Richmond, VA 23232	N/A	Certified Mail

# 3. Mailroom Procedures

## 3.1. Secure Packaging and Mailing

### Procedure:

1. Take items to mailroom
2. Shipping/Mail Carriers:
  - a. United States Postal Service
  - b. UPS/FedEx/DHL
  - c. Commercial Courier
3. Special Considerations:
  - a. Commercial Courier  
(Must be point-to-point courier with no change of vehicle or custody to minimize chances of loss during courier shipment)
4. Letters and Letter Size Mailing
  - a. Do not over-stuff letter envelope. The envelope must not bulge, and the seal must not be in danger of breaking open
  - b. In general, business unit locations can mail a single letter envelope containing PI via USPS First Class without insurance or tracking
  - c. Always use bubble wrap envelopes to ship CDs and DVDs. Place the bubble wrap envelope inside another container according to double wrapping techniques. Double wrapping is essential to protect the media from breakage and theft
  - d. Use "Express Box" as the outer container for larger quantities of paper documents
5. Double Wrapping Techniques:
  - a. When using large envelopes (excluding letter size) or boxes for mailing or shipping Confidential Information, use a double wrapping technique. Double wrapping technique provides the best possible security for the data/material being shipped by decreasing the chance of a box breaking open and spilling the contents
  - b. Place information or media inside a new envelope or new/undamaged box
  - c. Address the envelope or box with permanent black marker or attach a second shipping label. Place your return address on the container. If the outer box breaks open, the address on the inner envelope or box will still provide the shipper the correct recipient and address
  - d. Secure the shipping label using clear packing tape on the edges of the label to ensure the label does not come off in transit. DO NOT cover barcodes with clear tape! Covering the barcodes with tape can obscure the barcode and increase the possibility of an error in delivery
  - e. Seal all seams and openings with filament or strapping tape to increase strength and stability of a corrugated container or envelope
  - f. Place the first envelope in a second envelope or container, apply a shipping label (again, secure label edges with clear tape, avoiding the barcode), and seal all seams and openings with filament or strapping tape to increase strength and stability of the outer container

## 3.2. Suspicious Mail Handling

**IMPORTANT:** If an envelope arrives with powder or powder spills on the surface, see the Suspicious Mail poster in section 10.

1. All employees who process incoming mail or packages should be alert for unusual or suspicious letters or packages that may arrive in mailrooms, reception areas, or receiving docks.
2. Display Suspicious Mail, Suspicious Letter, and/or Suspicious Package posters in all mail receiving areas.
3. Ensure mail handlers are aware of suspicious mail indicators:
  - Postmark does not agree with return address
  - Restrictive markings, such as “Confidential” or “Personal”
  - An excessive number of postage stamps (instead of USPS meter label)
  - An odd wrapping material, e.g. waterproof paper
  - A return address that is either foreign or not associated with any of the [REDACTED] International locations; or, an unusual writing style
  - Handwritten or typed address, either poorly written or typed on older equipment, i.e. letter height variance or heavier type of select letters
  - Packages / envelopes lacking a return address
  - A package addressed to a corporate title, without the person’s name
  - Common words incorrectly spelled
  - A package whose weight is unbalanced
  - An envelope that feels spongy
  - Small wires protruding from package
  - Pin pricks or holes in envelope
  - Greasy patches on wrapping paper or envelope
  - An envelope that feels uncommonly stiff; or lopsided; or, uneven
  - A package with an inner sealed enclosure. **DO NOT OPEN!**

## 3.3. Excessive tape or string used to seal the parcel

- Any package with a strange smell
- Parcels that are not delivered by the usual carrier, or delivery person not in uniform or common apparel for carrier. Delivery to an unusual place
- A type of package or envelope that has not been observed before in the routine course of business
- Any other observable fact or set of circumstances that suggest the piece may be dangerous

### **What to do**

Leave the package undisturbed!

Calmly evacuate the room and the surrounding areas, if necessary

During evacuation, leave doors and windows open

Keep people away from the area

Notify VAMMIS Senior Management

## 3.4. Receiving US Postal Service and Interoffice Mail

Each business day, the courier picks up mail from the post office, DMAS and [REDACTED] St locations and delivers it to the mailroom at the Boulder's facility for screening. The mailroom receives mail picked up by the courier from the post office separated by individual post office box. Mail addressed to an individual, or marked **Personal** or **Confidential** is extracted and then distributed through interoffice delivery unopened as addressed.

### Procedure:

1. Review the address of each mail piece by individual post office box address.
2. Stage mail pieces addressed to a particular individual, or marked personal or confidential, for distribution through interoffice delivery, unopened as addressed.

All mail addressed to an individual must be delivered through an interoffice mail run to the named individual. If there is a question, bring the mail to the Claims Services Manager's attention for clarification.

3. If mail piece is not addressed to a particular individual or marked personal or confidential, treat as regular incoming mail and process documents as instructed in Section 4.

The claims mail is placed in trays for letter size envelopes and in tubs for large flat envelopes.

## 3.5. Receiving Certified Mail

Each business day, the courier picks up certified mail from the post office and delivers it to the Mailroom. The mailroom receives certified mail picked up by the courier from the Postal Service and then sorts and distributes to the particular individual or processing unit. Mail addressed to a particular individual, or marked **Personal** or **Confidential** is distributed unopened as addressed. All certified mail pieces are dated, copied and stored in the **Certified Mail** notebook.

### Procedure:

1. Document the receipt date on all certified envelopes. Make copies of each envelope ensuring the tracking number is displayed and readable. Place copies in the Certified Mail logbook located in the Mailroom.
2. Stage mail pieces addressed to a particular individual, or marked personal or confidential, for distribution through interoffice delivery, unopened as addressed.

All mail addressed to an individual must be delivered through an interoffice mail run to the named individual. If there is a question, bring the mail to the Claims Services Manager's attention for clarification.

3. If mail piece is not addressed to a particular individual or marked Personal or Confidential, treat as regular incoming mail and process documents as instructed in Section 4.

## 3.6. Outgoing Mail Interoffice Mail

Each business day, the courier picks up interoffice mail from the Mailroom and then delivers to the DMAS and ██████ - Franklin Street facilities. DMAS and ██████ Franklin Street office are responsible for the distribution of mail for their facilities.

**Procedure:**

1. Sort each mail piece by facility destination (DMAS or ██████ Franklin Street Office).
2. Bundle or place mail pieces into bin by facility destination.
3. Attach the destination identifier to the top of each bundle.
  - a. DMAS – Customer Services  
████████████████████
4. Stage bundled mail for courier pickup.

## 3.7. Outgoing US Postal Service Mail and Postage

Outgoing mail is sorted into different categories for accounting purposes;

1. VA MMIS ██████ – ██████ Regular Outgoing Mail
2. MLR/RTRN TO PROVIDER – Mailroom/Return to Provider
3. FIN/CHECKS – Finance/Checks
4. CLMS/TAD – Claims/TAD Letters
5. PES/APPR LTRS – Provider Enrollment Services/Approval Letters
6. PES/REJ LTRS – Provider Enrollment Services/Rejection Letters
7. PES/ENROLL APP REQUEST – Provider Enrollment Services/ Enrollment Application Request
8. PES/DUPLICATE 1099 – Provider Enrollment Services/Duplicate 1099
9. PES/APPR PART AGREEMENT – Provider Enrollment Services/ Copy of Approved Participation Agreements
10. PES/RTRN MAIL LTRS – Provider Enrollment Services/Return Mail Letters
11. QA/SATISFACT SURVEY – Quality Assurance/Satisfaction Surveys
12. ID CARDS/NEW ADDRESS – ID Cards
13. Call Center – ██████ Call Center Mail

Monthly postage costs are passed through to DMAS. As a result, the accurate capture of postage expenses is critical. Postage availability on the meter is monitored daily and where necessary postage is increased by phone. If more postage is required, add additional postage using the steps located under Refill Postage Meter procedures Section 3.5.

**Procedure:**

1. Identify postage category.

2. Enter the postage accounting number.
3. Verify postage cost according to mail piece weight.
4. Meter mail piece.
5. Place postage on envelope.

## 3.8. Refill Postage Meter

The postage machine utilizes a 'Postage by Phone' meter. This allows the meter refills via phone or Internet. The Claims Manager can refill the meter by disconnecting the Control Center from the base and connecting it directly to an analog phone line. Once connected the Control Center will auto dial the postage by phone number where funds load to the meter.

### Procedure:

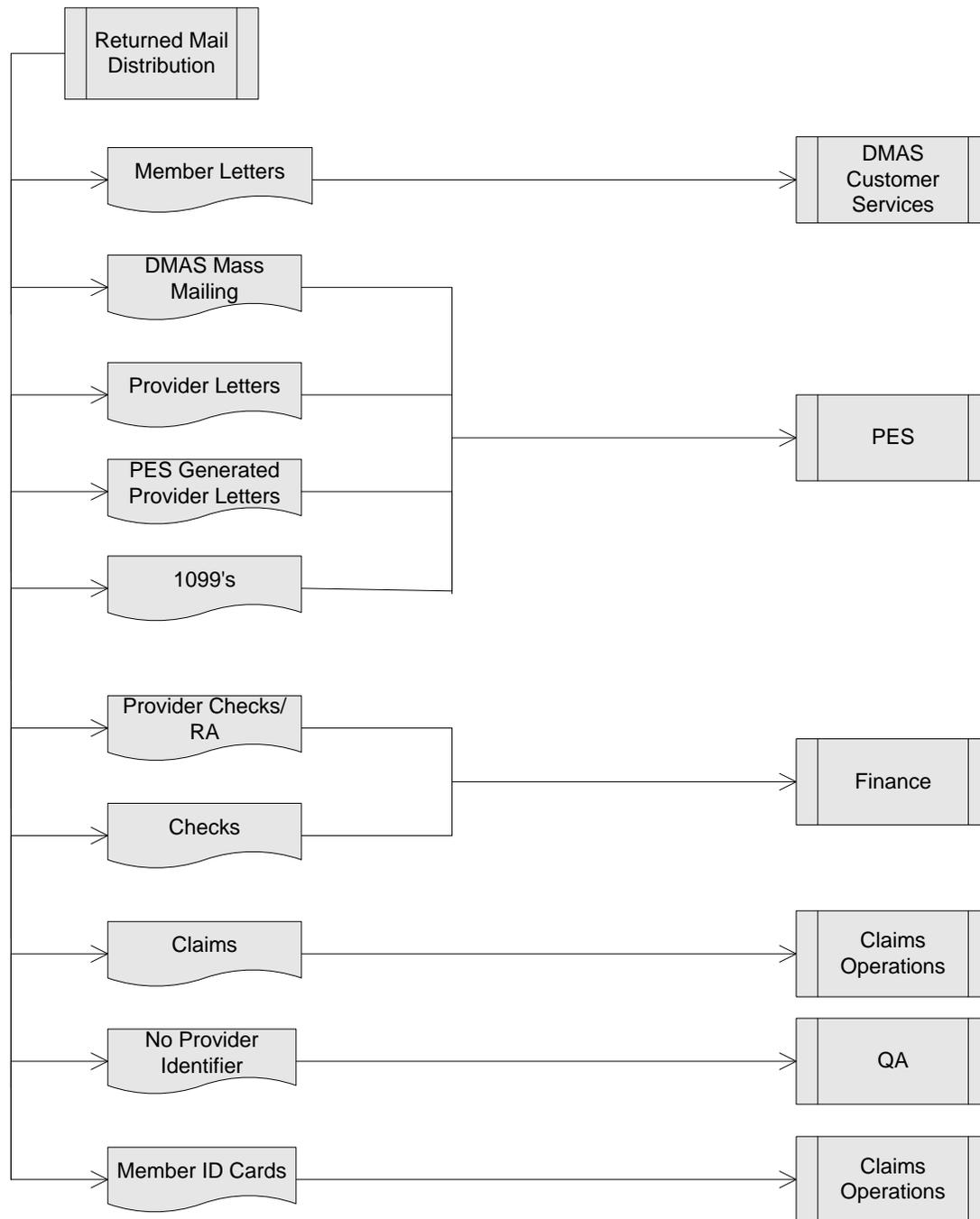
1. Contact the Claims Manager or Mailroom Lead administrative assistant when postage meter is at \$50.00 or lower.
2. Only the Claims Manager and Mailroom Lead have access to add postage to the postage machine.

## 3.9. Returned Mail Distribution

On a daily basis, all outbound mail marked as "**Undeliverable**" by the Post Office or "**Returned By The Addressee**" are delivered to the Mailroom for processing. The Mailroom opens and sorts returned mail by document type and then distributes to the appropriate processing unit as illustrated in the following diagram.

### Returned Mail Distribution Workflow

This diagram presents a graphic depiction of the document preparation, scanning, and data capture processes.



**Sorting Returned Mail**

Sort returned mail by the following types and distribute to the locations noted:

1. **Member Letters:** Distribute to DMAS Customer Services for processing after balancing against postage report sent by USPS.
2. **DMAS Mass Mailing (Commonwealth Martin):** Distribute to Provider Enrollment Services for processing.
3. **Provider Letters:** Distribute to Provider Enrollment Services for processing.
4. **Provider Enrollment Services Generated Letters:** Distribute to Provider Enrollment

Services for process.

5. **1099's:** Distribute to Provider Enrollment Services for processing.
6. **Member ID Cards:** Distribute to Claims Services for processing.
7. **Provider Checks/Remittance Advices:** Go to Returned Checks and Provider Checks/Remittance Advices procedures Section 3.6.3
8. **Checks:** Go to Returned Checks and Provider Checks/Remittance Advices procedures Section 3.6.3.
9. **Claims:** Distribute to Claims Unit for address verification in MMIS. If address matches, claims are shredded. If address does not match, claims are sent to new address.
10. **No Provider Identifier:** Distribute to QA Unit for processing.

Returned Checks and Provider Checks/Remittance Advices

1. Fill in the Check Log with the following information.

Field Description	Instructions
Receipt Date	Document date of receipt
Provider Name	Document Pay To The Order name or organization
Check Number	Document the check number located on right side of check
Check Amount	Document the check number located on the right side of check
Associate Initials	Document your initials in the column beside the check entry

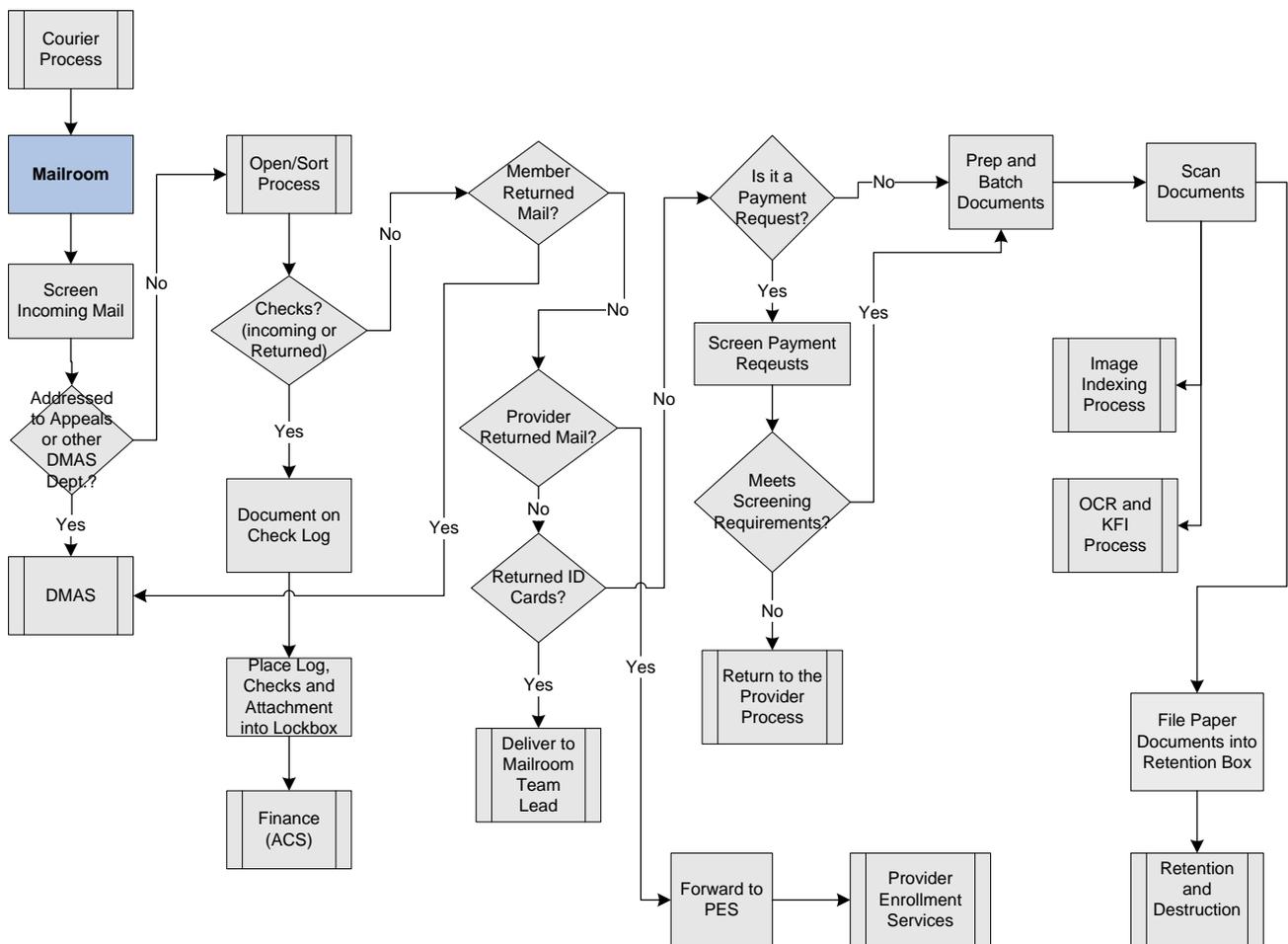
2. Return check and document into envelope.
3. Place envelope with contents into the lockbox.

# 4. Document Control Procedures

Document Control opens, sorts, screens, batches and scans incoming documents. Images are then indexed in preparation for archiving into the Enterprise Content Manager and distribution to Provider Enrollment Services, Financial Services and Claims Services. Document Control also processes returned Member ID Cards, prepares claims for mailing that were identified to Return to the Provider or Return to DMAS; and manages document storage, retention and destruction.

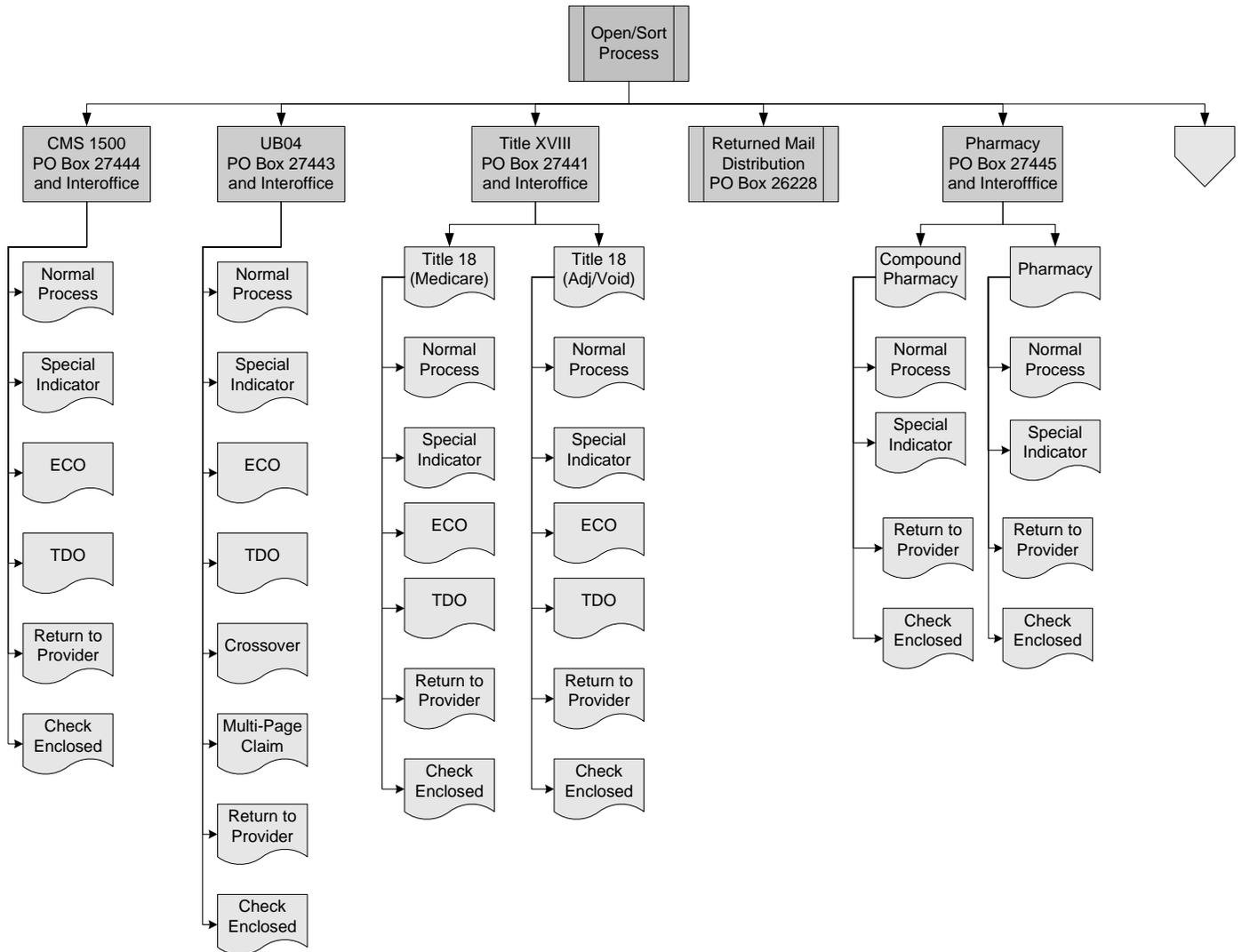
## 4.1. Document Control Workflow

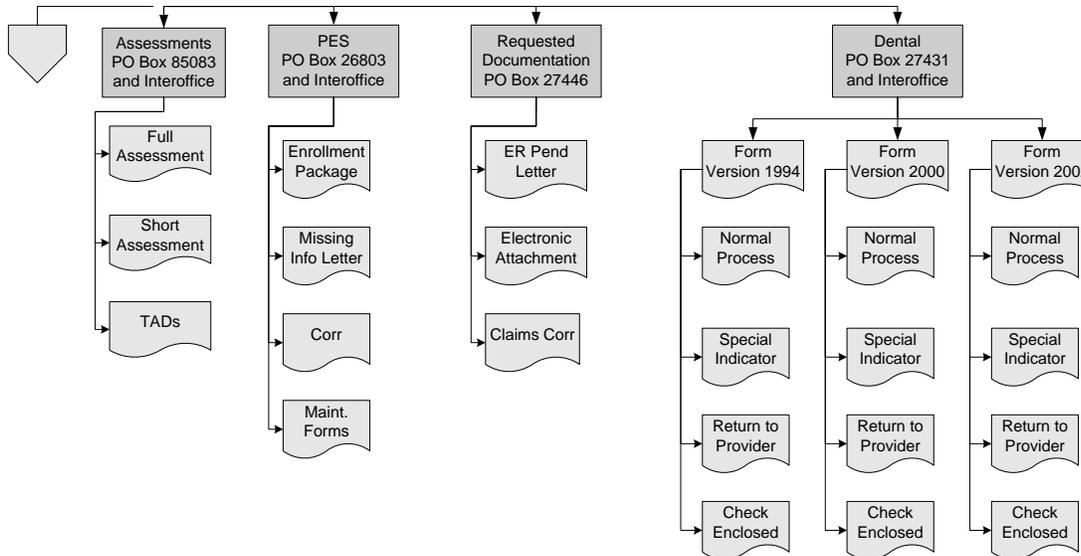
This diagram presents a graphic depiction of the document preparation, screening, and scanning processes.



## 4.2. Mail Opening and Sorting Workflow

This diagram presents a graphic depiction of the document preparation, screening, and scanning processes.





## 4.2.1. CMS 1500 (PO Box 27444) Sorting, Screening and Batching Procedure

CMS 1500 claims will be processed by [REDACTED] [REDACTED]. All procedures are the same except where noted.

### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments. When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.
  - a. Do not discard envelope until screening process is complete. Envelope may be required to return claim to the Provider
  - b. If checks or checks and claims are enclosed, document the receipt date, check number, check amount, associate initials and provider/organization name from the top of the check (Not the PAY TO Name) on the Check Log. Insert contents (Checks or Checks and Claims) into original envelope. Insert envelope and check log into the Financial Services lockbox
  - c. If no checks are enclosed, go to step 2.
2. Perform screening process listed below:
  - a. All payment requests must be a valid claim form.
  - b. Black/White and Red/White forms are accepted.
  - c. Review form version located at the bottom right corner. Valid form version is CMS1500 (02-12)12
  - d. If the form version is valid, perform the next screening step.

- e. If the form version is not valid shred. See Return to Provider procedures in Section 4.3 for further instructions.
3. All paper payment requests data must be black or dark ink.
    - a. If the payment request data is black or dark ink, perform the next screening step.
    - b. If the payment request data is not black or dark ink, return payment request to the Provider. Document return Reason as "ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY". See return to Provider procedures for further instructions. (Section 4.3).
  4. If the signature field is blank, return payment request to the Provider. Document return reason as "AUTHORIZED SIGNATURE/DATE MISSING". See Return to Provider/DMAS procedures in section 4.3 for further instructions.
  5. Screen claim payment requests and attachments for document repairs.
    - a. Repair torn documents.
    - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper.
    - c. Remove staples and paper clips
  6. Screen to identify Crossover Payment requests
    - a. If block 11c is coded with "Crossover" or "Cross Over", separate payment requests into a separate group
      - i. Invalid variations of a Crossover Payment Request are noted below and should be processed as a CMS 1500 claim:
        1. HMO Copay/Crossover
        2. Medicare/Crossover
  7. Separate **CMS 1500** Payment Requests by scanner job type:
    - a. If envelope has more than one payment request enclosed, each payment request is processed individually. This includes:
      - i. Typed Single page payment request without an attachment
      - ii. Typed Single page payment request with an attachment
      - iii. Handwritten Single page payment request without an attachment
      - iv. Handwritten Single page payment request with an attachment
      - v. Typed Crossover Single page payment request without an attachment
      - vi. Typed Crossover Single page payment request with an attachment
      - vii. Handwritten Crossover Single page payment request without an attachment
      - viii. Handwritten Crossover Single page payment request with an attachment

**Note:**

1. Handwritten claims are distinguishable by reviewing the following fields:
  - a. (1a, 11,14,19,21,22,23,24a-24j,26,29,30,32,33,33a,33b)

2. If four or more captured fields are handwritten and it is a red form, the claim should be processed as handwritten. This does not include check mark boxes such as block 10 and 11d.
  3. Any detail lines that have been marked thru with a marker must be processed as handwritten.
  4. Multiple detail lines marked thru using white out should be processed as handwritten.
  5. Insert document separator page.
- b. If it is a single page claim without an attachment, do not insert a Document separator sheet.

██████████

If it is a single page claim with an attachment, insert the ██████████ Document separator page (identified by bar codes at the top and left side of the document) on top of each claim. The side barcode must be placed to the left of the claim for accurate scanning.

See Appendices 10 for an example of the ██████████ Document Separator page.

1. Complete the Batch Cover Sheet (Paper Claims):
  - c. Date Received
  - d. Document Control Associate Prep ID
  - e. Date
  - f. Process Type
  - g. Document Type
  - h. Processing Indicators
    1. Place the Stack Header and Batch Cover Sheet on top of the documents and secure batch with a rubber band.

See Appendices for an example of the Batch Cover Sheet and Stack Header.

2. Stage batched documents for scanning.

## 4.2.2. UB04 (PO Box 27443) Sorting, Screening and Batching Procedure

### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments.

When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.

- a. Do not discard envelope until screening process is complete. Envelope may be required to return claim to the Provider
  - b. If checks or checks and claims are enclosed, document the receipt date, check number, check amount, associate initials and provider/organization name from the top of the check (Not the PAY TO Name) on the Check Log. Insert contents (Checks or Checks and Claims) into original envelope. Insert envelope and check log into the Financial Services lockbox
  - c. If no checks are enclosed, go to step 2.
2. Perform screening process listed below:
- a. All payment requests must be a valid claim form
    - Black/White and Red/White forms are accepted.**
    - i. Review form Version located at the bottom left corner, Valid from version is UB-04 CMS 1450
    - ii. If the payment request is on the valid claim form, perform the next screening step.
    - iii. If the payment request is not on a valid claim form, return payment request to the Provider... Document the return reason as "CLAIM SUBMITTED ON AN OBSOLETE FORM". See Return To Provider procedures in Section 4.3 for further instructions.
  - b. All paper payment requests data must be black or dark ink.
    - i. If the payment request data is black or dark ink, perform the next screening step.
    - ii. If the payment request data is not black or dark ink, return payment request to the Provider. Document return reason as "ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY". See return to Provider procedures in Section 4.3 for further instructions.
3. Screen payment requests and attachments for document repairs:
- a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
  - d. Verify that block 4 (Type of Bill) is readable to prevent claim rejection
  - e. Identify multi-page payment requests.
    - i. Continuation claims have more detail charge lines that bill on a single page then continue on a second and/or third claim page. UB-04 payment requests may consist of up to 5-claim pages with Total Charge (line 0001) listed on the last page. Multi-page claims consisting of 6 or more pages should be returned to the provider.
    - ii. If the Total Charge is on page 1, process as a single page payment request.

- iii. If the Total Charges line 0001 is on page 2 through 5, create a separate batch to process as a multi-page claim.
    - iv. Multi-page claims with attachments can be batched and processed with multi-page claims without attachments.
  - f. Screen to identify payment requests that are required to process as “Crossover” payment requests.
    - i. If Block 30 has the word “Crossover” separate payment requests into a single group. The word “XOVER” or “CROSS” is not acceptable and should be processed as a UB04 claim.
- 4. Separate UB04 payment requests by scanner job type:
  - a. If an envelope has more than one payment request enclosed, each payment request is processed individually. This includes:
    - i. Typed Single Page Payment Request without an attachment
    - ii. Handwritten Single Page Payment Request without an attachment
    - iii. Typed Single Page Payment Request with an attachment
    - iv. Handwritten Single Page Payment Request with an attachment
    - v. Typed Multi Page payment request with or without an attachment
    - vi. Handwritten Multi Page payment request with or without an attachment
  - b. UB04 Crossover payment requests are identified manually. The word “Crossover” is found in Block 30. The word “Xover” or “CROSS” is not acceptable and should be processed as a UB04 claim.
    - i. Handwritten Crossover Payment Request, single page without an attachment
    - ii. Typed Crossover Payment Request, single page without an attachment
    - iii. Handwritten Crossover Payment Request, single page with an attachment
    - iv. Typed Crossover Payment Request, single page with an attachment
    - v. Handwritten Crossover Payment Request, multi-page without an attachment
    - vi. Typed Crossover Payment Request, multi-page without an attachment
    - vii. Handwritten Crossover Payment Request, multi-page with an attachment
    - viii. Typed Crossover Payment Request, multi-page with an attachment
  - c. If the form is red, all Rev Lines (Blocks 42 -48) must be typewritten in order to process as a Typewritten claim.
    - i. A document is considered handwritten if 4 or more of the above fields are handwritten by the provider
    - ii. White out only applies if used to mark out multiple Rev Lines (Blocks 42-48)
    - iii. Any Rev lines (Blocks 42-48) that have been marked thru with a marker must be processed as handwritten
- 5. Insert document separator pages.



- a. If it is a single page claim without an attachment, do not insert a Document Separator page.
  - b. If it is a single page claim with an attachment, insert the XXXXXXXXXX Document separator page (identified by bar codes at the top and left side of the document) on top of each claim. The side barcode must be placed to the left of the claim for accurate scanning
  - c. See Appendices 10 for an example of the London Document Separator page
  - d. If it is a Multi-page payment request without an attachment, insert the Document Separator page behind the last claim page (between the last claim page and first page of the next multi-page payment request)
  - e. If it is a Multi-page payment request with an attachment, insert the Document Separator page behind the last attachment of the claim
  - f. Remember that a Document Separator page must not be at the end of a stack of claims with attachments
6. Complete the Batch Cover Sheet (Paper Claims):
- a. Date Received
  - b. Document Control Associate Prep ID
  - c. Date
  - d. Process Type
  - e. Document Type
  - f. Processing Indicators
7. Place the Stack Header and Batch Cover Sheet on top of the documents and secure batch with a rubber band.
8. See Appendices for an example of the Batch Cover Sheet and Stack Header. Place the Batch Header Sheet on top of the documents and secure batch with a rubber band.
9. Stage batched documents for scanning.

### 4.2.3. Pharmacy and Compound Pharmacy (PO Box 27445) Sorting, Screening and Batching Procedure

#### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments. When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.

- a. Do not discard envelope until screening process is complete. Envelope may be required to return claim to the Provider
  - b. If checks or checks and claims are enclosed, document the receipt date, check number, check amount, associate initials and provider/organization name from the top of the check (Not the PAY TO Name) on the Check Log. Insert contents (Checks or Checks and Claims) into original envelope. Insert envelope and check log into the Financial Services lockbox
  - c. If no checks are enclosed, go to step 2
2. Perform screening process listed below:
- a. All payment requests must be a valid claim form.
 

**Black/White and Red/White forms are accepted**

    - i. Pharmacy - Review form Version located at the bottom left corner, Valid from version is DMAS 173 R 6/03
    - ii. Compound Pharmacy - Review form Version located at the bottom left corner, Valid from version is DMAS 174 R 6/03
    - iii. If the payment request is on the valid claim form, perform the next screening step.
    - iv. If the payment request is not on a valid claim form, Return payment request to the Provider. Document return reason as "CLAIM SUBMITTED ON AN OBSOLETE FORM". See Return to Provider procedures in Section 4.3 for further instructions
  - b. All paper payment requests data must be black or dark ink.
3. If the payment request data is black or dark ink, perform the next screening step.
4. If the payment request data is not black or dark ink, Return payment request to the Provider. Document return reason as "ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY". See return to Provider procedures in Section 4.3 for further instructions.
5. Screen claim payment requests and attachments for document repairs:
- a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
  - d. Screen Pharmacy payment requests for the following:
    - i. If Block 1 (Provider Medicaid ID) and Block 3 is blank, return claim to the Provider. Document return reason as "MISSING OR INVALID RENDERING AND/OR BILLING PROVIDER NUMBER(S)". See Return to Provider procedures Section 4.3. for further instructions
    - ii. If Block 32 (Signature) is blank, return claim to the provider. Document return reason as "AUTHORIZED SIGNATURE/DATE MISSING". See Return to Provider procedures Section 4.3 for further instructions
  - e. Screen Compound Pharmacy payment requests for the following:
    - i. If Block 4 (Provider Medicaid ID) and Block 9 is blank, return claim to the Provider. Document return reason as "MISSING OR INVALID RENDERING

AND/OR BILLING PROVIDER NUMBER(S). See Return to Provider procedures Section 4.3 for further instructions.

- ii. If Block 28 (Signature) is blank, return claim to the Provider. Document return reason as "AUTHORIZED SIGNATURE/DATE MISSING". See Return to Provider procedures Section 4.3 for further instructions.

6. Separate payment requests by type:

- a. Compound Pharmacy
- b. Pharmacy

7. Separate Compound Pharmacy and Pharmacy payment requests by scanner job type:

Each payment request must be grouped within form type:

- a. Compound Pharmacy Payment Request, without an attachment
- b. Compound Pharmacy Payment Request, with an attachment
- c. Pharmacy Payment Request, without an attachment
- d. Pharmacy Payment Request, with an attachment

8. Insert document separator pages.

- a. If it is a single page payment request without an attachment, do not insert a Document Separator.

**London**

If it is a single page claim with an attachment, insert the London Document separator page (identified by bar codes at the top and left side of the document) on top of each claim. The side barcode must be placed to the left of the claim for accurate scanning.

See Appendices 10 for an example of the London Document Separator page.

9. Complete the Batch Cover Sheet (Paper Claims):

- a. Date Received
- b. Document Control Associate Prep ID
- c. Date
- d. Process Type
- e. Document Type
- f. Processing Indicators

10. Place the Batch Cover Sheet on top of the documents and secure batch with a rubber band.

11. Stage batched documents for scanning.

## 4.2.4. Dental (PO Box 27431) Sorting, Screening and Batching Procedure

### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments. When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.
  - a. Do not discard envelope as all dental claims need to be returned to the provider
  - b. If checks or checks and claims are enclosed, document the receipt date, check number, check amount, associate initials and provider/organization name from the top of the check (Not the PAY TO Name) on the Check Log. Insert contents (Checks or Checks and Claims) into original envelope. Insert envelope and check log into the Financial Services lockbox
  - c. If no checks are enclosed, go to Step 2
2. All dental claims are returned to provider with a return to provider cover sheet with reason "SUBMIT TO DMAS CONTRACTOR (DENTAL, PA, etc)" clearly marked
3. Initial and date return to provider cover sheet and place inside addressed envelope
4. Place envelope in Outgoing US Mail to stage for postage

## 4.2.5. Temporary Detention Order (TDO), Emergency Custody Order (ECO) and Special Indicator Batch Sorting, Screening and Batching Procedure

DMAS submits TDO, ECO and Special Indicator Batch payment requests to Document Control with an identifier to process as ECO, TDO or Special Indicator payment requests. Claims without an identifier should be processed as original claims.

### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments.
2. Review the process identifier cover page and separate payment requests by ECO, TDO and Special Indicator Batch.
3. Sort ECO payment requests by document type:
  - a. CMS1500
  - b. CMS1500 Crossover
  - c. UB04
  - d. UB04 Crossover
  - e. Pharmacy, Compound Pharmacy and Dental payment requests do not apply.
4. Sort TDO payment requests by document type:
  - a. CMS1500
  - b. CMS1500 Crossover

- c. UB04
  - d. UB04 Crossover
  - e. Pharmacy, Compound Pharmacy and Dental payment requests do not apply.
5. Sort Special Indicator Batch payment requests by document type:
- a. CMS1500
  - b. CMS1500 Crossover
  - c. UB04
  - d. UB04 Crossover
  - e. Pharmacy
  - f. Compound Pharmacy
6. Go to section for procedures
- a. CMS1500 and CMS1500 Crossover – Section 4.2.5.1
  - b. UB04 and UB04 Crossover– Section 4.2.5.2
  - c. Pharmacy and Compound Pharmacy – Section 4.2.5.3

#### 4.2.5.1. TDO, ECO and Special Indicator Batch - CMS 1500 Payment Request

##### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments. When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.
2. Perform screening process listed below:
  - a. All payment requests must be a valid claim form.
  - b. Black/White and Red/White forms are accepted.**
  - c. Review form Version located at the bottom right corner. Valid form Version is CMS-1500 08-05.
    - i. If the payment request is on the valid claim form, perform the next screening step
    - ii. If the payment request is not on a valid claim form, Return payment request to DMAS Payment Processing Unit. Document return reason as “CLAIM SUBMITTED ON AN OBSOLETE FORM”. See return to Provider/DMAS procedures in Section 4.3 for further processing instructions
3. All paper payment requests data must be black or dark ink.
  - a. If the payment request data is black or dark ink, perform the next screening step
  - b. If the payment request data is not black or dark ink, return payment request to DMAS Payment Processing Unit. Document return reason as “ENTER CLAIM INFORMATION

IN BLACK INK ONLY". See return to Provider/DMAS procedures Section 4.3 for further instructions

4. If the signature field is blank, return payment request to the DMAS sender. Document return reason as "AUTHORIZED SIGNATURE/DATE MISSING". See Return to Provider/DMAS procedures in Section 4.3 for further instructions.
5. Screen claim payment requests and attachments for document repairs.
  - a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
6. Screen to identify Crossover Payment requests
  - a. If block 11c is coded with "Crossover" or "Cross Over", separate payment requests into a separate group
    - i. Invalid variations of a Crossover Payment Request are noted below and should be processed as a CMS 1500 claim:
      1. HMO Copay/Crossover
      2. Medicare/Crossover
7. Separate **CMS 1500** Payment Requests by scanner job type:
  - a. If envelope has more than one payment request enclosed, each payment request is processed individually. This includes:
    - i. Typed Single page payment request without an attachment
    - ii. Typed Single page payment request with an attachment
    - iii. Handwritten Single page payment request without an attachment
    - iv. Handwritten Single page payment request with an attachment
    - v. Typed Crossover Single page payment request without an attachment
    - vi. Typed Crossover Single page payment request with an attachment
    - vii. Handwritten Crossover Single page payment request without an attachment
    - viii. Handwritten Crossover Single page payment request with an attachment

**Note:**

1. Handwritten claims are distinguishable by reviewing the following fields:
  - a. (1a, 11,14,19,21,22,23,24a-24j,26,29,30,32,33,33a,33b)
2. If four or more captured fields are handwritten and it is a red form, the claim should be processed as handwritten. This does not include check mark boxes such as block 10 and 11d.
3. Any detail lines that have been marked thru with a marker must be processed as handwritten.
4. Multiple detail lines marked thru using white out should be processed as handwritten.

8. TDO and ECO claims will be submitted with a cover sheet identifying the code to be coded within block 9 of each CMS 1500 claim. Code a "T" for TDO and an "E" for ECO as indicated on the cover sheet. The cover sheet is placed as the last attachment within the batch.
9. Insert document separator page.
  - a. If it is a single page claim without an attachment, do not insert a Document  
[REDACTED]
  - If it is a single page claim with an attachment, insert the [REDACTED] Document separator page (identified by bar codes at the top and left side of the document) on top of each claim. The side barcode must be placed to the left of the claim for accurate scanning.
10. Complete the Batch Cover Sheet (Paper Claims):
  - a. Date Received
  - b. Document Control Associate Prep ID
  - c. Date
  - d. Process Type
  - e. Document Type
  - f. Processing Indicators
11. Place the Stack Header and Batch Cover Sheet on top of the documents and secure batch with a rubber band.
12. Stage batched documents for scanning.

#### 4.2.5.2. TDO, ECO and Special Indicator Batch - UB04 Payment Request

##### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments. When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.
2. Perform screening process listed below:
  - a. All payment requests must be a valid claim form
    - i. **Black/White and Red/White forms are accepted.**
    - ii. Review form Version located at the bottom left corner. Valid form Version is UB-04 CMS 1450
    - iii. If the payment request is on the valid claim form, perform the next screening step.
    - iv. If the payment request is not on a valid claim form, return payment request to DMAS Payment Processing Unit. Document return reason as "CLAIM SUBMITTED ON AN OBSOLETE FROM". See Return To Provider/DMAS procedures in Section 4.3 for further instructions.
  - b. All paper payment requests data must be black or dark ink.

- i. If the payment request data is black or dark ink, perform the next screening step.
  - ii. If the payment request data is not black or dark ink, return payment request to DMAS Payment Processing Unit. Document return reason as “ENTER CLAIM INFORMATION IN BLACK INK ONLY”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
- 3. Screen payment requests and attachments for document repairs:
  - a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
- 4. Identify multi-page payment requests:
 

Continuation claims have more detail charge lines that bill on a single page then continue on a second and/or third claim page. UB-04 payment requests may consist of up to 5-claim pages with Total Charge (line 0001) listed on the last page.

  - a. If the Total Charge is on page 1, process as a single page payment request
  - b. If the Total Charges line 0001 is on page 2 through 5, create a separate batch to process as a multi-page claim
- 5. Screen to identify payment requests that are required to process as “Crossover” payment requests.
 

**If Block 30 has the word “Crossover” separate payment requests into a single group.**
- 6. Separate UB04 payment requests by scanner job type:
  - a. TDO Payment Request, single page without an attachment
  - b. TDO Payment Request, single page with an attachment
  - c. TDO Payment Request, multi-page without an attachment
  - d. TDO Payment Request, multi-page with an attachment
  - e. ECO Payment Request, single page without an attachment
  - f. ECO Payment Request, single page with an attachment
  - g. ECO Payment Request, multi-page without an attachment
  - h. ECO Payment Request, multi-page with an attachment
  - i. Special Indicator Batch Payment Request, single page without an attachment
  - j. Special Indicator Batch Payment Request, single page with an attachment
  - k. Special Indicator Payment Request, multi-page without an attachment
  - l. Special Indicator Batch Payment Request, multi-page with an attachment

**UB04 Crossover payment requests are identified manually. The word “Crossover” is found in Block 30.**

  - m. TDO Crossover Payment Request, single page without an attachment
  - n. TDO Crossover Payment Request, single page with an attachment
  - o. TDO Crossover Payment Request, multi-page without an attachment

- p. TDO Crossover Payment Request, multi-page with an attachment
  - q. ECO Crossover Payment Request, single page without an attachment
  - r. ECO Crossover Payment Request, single page with an attachment
  - s. ECO Crossover Payment Request, multi-page without an attachment
  - t. ECO Crossover Payment Request, multi-page with an attachment
  - u. Special Indicator Batch Crossover Payment Request, single page without an attachment
  - v. Special Indicator Batch Crossover Payment Request, single page with an attachment
  - w. Special Indicator Batch Crossover Payment Request, multi-page without an attachment
  - x. Special Indicator Batch Crossover Payment Request, multi-page with an attachment
7. TDO and ECO claims will be submitted with a cover sheet identifying the code to be coded within block 37 of each UB Crossover claim. Code a "T" for TDO and an "E" for ECO as indicated on the cover sheet.
8. Insert document separator page.

**London**

- a. If it is a single page claim without an attachment, do not insert a Document Separator page
  - b. If it is a single page claim with an attachment, insert the London Document separator page (identified by bar codes at the top and left side of the document) on top of each claim. The side barcode must be placed to the left of the claim for accurate scanning
  - c. See Appendices 10 for an example of the London Document Separator page
  - d. If it is a Multi-page payment request without an attachment, insert the Document Separator page behind the last claim page (between the last claim page and first page of the next multi-page payment request)
  - e. If it is a Multi-page payment request with an attachment, insert the Document Separator page behind the last attachment of the claim
  - f. Remember that a Document Separator page must not be at the end of a stack of claims with attachments
9. Complete the Batch Cover Sheet (Paper Claims):
- a. Date Received
  - b. Document Control Associate Prep ID
  - c. Date
  - d. Process Type
  - e. Document Type
  - f. Processing Indicators
10. Place the Stack Header and Batch Cover Sheet on top of the documents and secure batch with a rubber band.
11. Stage batched documents for scanning.

#### 4.2.5.3. Special Indicator Batch – Pharmacy and Compound Pharmacy Payment Requests

##### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments. When multiple invoice types are attached (stapled) without any other attachments, process as individual claim types. When multiple invoice types are attached (stapled) with attachments, process claims separately and leave the attachments to the last claim.
2. Perform screening process listed below:
  - a. All payment requests must be a valid claim form.
  - b. Black/White and Red/White forms are accepted.**
  - c. Pharmacy – Review form Version located at the bottom left corner. Valid form Version is DMAS 173 R 6/03
  - d. Compound Pharmacy – Review form Version located at the bottom left corner. Valid form Version is DMAS 174 R 6/03
  - e. If the payment request is on the valid claim form, perform the next screening step
  - f. If the payment request is not on a valid claim form, Return payment request to DMAS Payment Processing Unit. Document return reason as “CLAIM SUBMITTED ON AN OBSOLETE FORM”. See return to Provider/DMAS procedures in Section 4.3 for further instructions. See Return to Provider procedures in Section 4.3
  - g. All paper payment requests data must be black or dark ink.
    - i. If the payment request data is black or dark ink, perform the next screening step.
    - ii. If the payment request data is not black or dark ink, Return payment request to DMAS Payment Processing Unit. Document return reason as “ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
  - h. Screen claim payment requests and attachments for document repairs
    - i. Repair torn documents
    - ii. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
    - iii. Remove staples and paper clips
  - i. Separate payment requests by for type:
    - i. Compound Pharmacy
    - ii. Pharmacy
  - j. Screen Pharmacy payment requests for the following:
    - i. If Block 1 (Provider Medicaid ID) does not have a numeric value, return claim to the DMAS Payment Processing Unit. Document return reason as “MISSING AND/OR RENDERING BILLING PROVIDER NUMBER(S)”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.

- ii. If Block 3 (Patient Medicaid ID) does not have a numeric value, return claim to the DMAS payment Processing Unit. Document return reason as “INSUFFICIENT INFORMATION FOR PROCESSING (Each block must be completed properly. See billing instructions”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
    - iii. If Block 32 (Signature) is blank return claim to DMAS Payment Processing Unit. Document return reason as “AUTHORIZED SIGNATURE/DATE MISSING”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
  - k. Screen Compound Pharmacy payment requests for the following:
    - i. If Block 4 (Provider Medicaid ID) does not have a numeric value, return claim to DMAS. Document return reason as “MISSING AND/OR RENDERING BILLING PROVIDER NUMBER(S)”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
    - ii. If Block 9 (Patient Medicaid ID) does not have a numeric value, return claim to DMAS Payment Processing Unit. Document return reason as “INSUFFICIENT INFORMATION FOR PROCESSING (Each block must be completed properly. See billing instructions”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
    - iii. If Block 28 (Signature) is blank, , return claim to DMAS Payment Processing Unit. Document return reason as “AUTHORIZED SIGNATURE/DATE MISSING”. See return to Provider/DMAS procedures in Section 4.3 for further instructions.
  - l. Separate Compound Pharmacy and Pharmacy payment requests by scanner job type:
    - i. Each payment request must be grouped within form type.
    - ii. Special Indicator Batch, Compound Pharmacy Payment Request, without an attachment
    - iii. Special Indicator Batch, Compound Pharmacy Payment Request, with an attachment
    - iv. Special Indicator Batch, Pharmacy Payment Request, without an attachment
    - v. Special Indicator Batch, Pharmacy Payment Request, with an attachment

3. Insert document separator pages.

- a. If it is a single page payment request without an attachment, do not insert a Document Separator sheet.



If it is a single page claim with an attachment, insert the London Document separator page (identified by bar codes at the top and left side of the document) on top of each claim. The side barcode must be placed to the left of the claim for accurate scanning.

See Appendices 10 for an example of the London Document Separator page.

4. Complete the Batch Cover Sheet:

- a. Date Received
- b. Document Control Prep ID
- c. Date

- d. Process Type
- e. Document Type
- f. Processing Indicators
- g. Special Indicator
- h. Place the Batch Cover Sheet on top of the documents and secure batch with a rubber band.
- i. Stage batched documents for scanning.

## 4.2.6. Assessments and Turnaround Documents (PO Box 85083) Sorting, Screening and Batching Procedure

### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments.
  - a. Do not discard envelope until screening process is complete. Envelope may be required to return claim to Provider
  - b. If checks or checks and claims are enclosed, document the receipt date, check number, check amount, associate initials and provider/organization name from the top of the check (Not the PAY TO Name) on the Check Log. Insert contents (Checks or Checks and Claims) into original envelope. Insert envelope and check log into the Financial Services lockbox
  - c. If no checks are enclosed, go to step 2
2. Screen documents and attachments for document repairs:
  - a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
3. As of 12/17/16, only paper Hospital Assessments will be processed by ██████████
  - a. If the type of Assessment is questionable, Look up the Provider ID in the MMIS to determine if it's a Hospital
4. Separate documents by form type:
  - a. Short Assessment
    - i. Review the assessment type located on the left column of the DMAS 96 form. If the "ALF Reassessment Completed" field value is "2", it is a short assessment
  - b. Full Assessment
    - i. Review the assessment type located on the left column of the DMAS 96 form. If the "ALF Reassessment Completed" field value is "1", it is a full assessment

- c. Turnaround Document
  - i. Review the first paragraph of the letter. If letter states that “a screening assessment form was submitted for processing”, it is a Turnaround Document
  - ii. The Turnaround Document Letter must be the first page of the document
5. Insert Document Separator page behind the last page of each assessment.
6. Complete the Batch Cover Sheet (Datacap):
  - a. Date Received
  - b. Document Control Associate Prep ID
  - c. Date
  - d. Document Type
  - e. Processing Indicators
7. Place the Batch Cover Sheet on top of the documents and secure batch with a rubber band.
8. Fill out the LTC Validation Count sheet by logging the date, JD, Prepper id. Batcher id, the total counts of each assessment type, Number of batches and Number of rejects for each type.
9. Stage for scanning.
10. Once scanned, staple according to type of document (Full Assessment, Short Assessment, or Turnaround Document).

## 4.2.7. ER Pend Letter, Electronic and Direct Data Entry Attachments (PO Box 27446) Sorting, Screening and Batching Procedure

### Procedure:

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments.
  - a. If checks or checks and claims are enclosed, document the receipt date, check number, check amount, associate initials and provider/organization name from the top of the check (Not the PAY TO Name) on the Check Log. Insert contents (Checks or Checks and Claims) into original envelope. Insert envelope and check log into the Financial Services lockbox
  - b. If no checks are enclosed, go to step 2.
2. Screen documents and attachments for document repairs:
  - a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
3. Separate documents by form type:
  - a. ER Pend Letter

- i. Review the bottom left corner of the letter. If the letter ID is CP-O-444-04, CPO-444-05, CPO-444-06 and CPO-445, it is a ER Pend Letter
    - ii. The ER Pend Request Letter must be the first page of the document
    - iii. If a CD is included it should remain with the letter and forwarded to DMAS along with the letter
  - b. Electronic Attachment
    - i. The Electronic Attachment form title is "Claim Attachment Form". In addition, version DMAS 3 R 6/03 is located in the bottom left corner of form
    - ii. The Electronic Attachment information page must be the first page of the document
      1. If both an Electronic and Direct Data Entry Claim Attachment Submittal form is received with attachments as one set of documents, process the set of documents with the top form using all other documents as documentation
  - c. Direct Data Entry Attachment
    - i. The Direct Data Entry Attachment form title is "Claim Submittal"
    - ii. The Direct Data Entry Attachment Claim Submittal page must be the first page of the document
    - iii. If both an Electronic and Direct Data Entry Claim Attachment Submittal form is received with attachments as one set of documents, process the set of documents with the top form using all other documents as documentation
4. Insert Document Separator page behind the last page of the packet.
  - a. ER Pend Letters do not require scanning therefore do not require document separator sheets.
5. Complete the Batch Cover Sheet (Datacap):
  - a. Date Received
  - b. Document Control Associate Prep ID
  - c. Date Prepped
  - d. Document Type
  - e. Processing Indicators
6. Place the Batch Cover Sheet on top of the documents and secure batch with a rubber band.
7. Stage batched documents for scanning.
8. Once scanned, the documents are taken to the Claims Services Supervisor for distribution of work.

## 4.2.8. Provider Enrollment Services Documents (PO Box 26803) Sorting, Screening and Batching Procedure

### Procedure:

#### Screening

1. Remove the contents of each envelope; unfold the contents; remove all paper clips, staples, or other fasteners, ensuring that the source document remains with its associated attachments.
  - a. Do not discard envelope until screening process is complete. Envelope may be required to return documents to Provider
  - b. If checks are enclosed, log the receipt date, check number, check amount and Provider/Organization name on the Check Log, insert contents into original envelope and place in the Financial Services lock box.
    - i. If a paper check and/or an Application Fee Submission Form is enclosed within a **New Enrollment Application packet**, process the New Enrollment Application, set both the check and/or Application Fee Submission Form to the side. If a check is attached, Log the receipt date, check number, check amount and Provider/Organization name from the check into the Check Log and drop items into the Financial Services lock box. If the Fee Form is by itself (blank or coded with information) drop into the Financial Services lock box
    - ii. If an Application/Revalidation – Check Payment Form is submitted with a check, set both the check and Application/Revalidation Form to the side. Log the receipt date, check number, check amount and Provider/Organization name from the check into the Check Log and drop items into the Financial Services lock box. If the Application/Revalidation – Check Payment Form is (blank with no check, drop the blank form into the Financial Services lock box
    - iii. If an Application/Revalidation – Credit card Payment by Mail form is submitted, drop into the Financial Services lock box. This form contains credit card information and is similar to the Application/Revalidation – Check Payment form. The difference is that this form will not have a check attached
2. Screen documents and attachments for document repairs:
  - a. Repair torn documents
  - b. Pages not standard 8 ½ x 11 are taped onto 8 ½ x 11 paper
  - c. Remove staples and paper clips
3. Claim forms such as CMS 1500 and UB04 remains with received documents.
4. Stamp documents received by mail with the receipt date

#### Sorting

1. Sort documents by the following Document Types:

- a. Old Applications
  - i. Place entire old application in the “Old Application” basket to be delivered to PES at the end of the day.
- b. New Enrollment Applications
  - i. The first page of a New Enrollment Application is titled “Virginia Medical Assistance Program Provider Enrollment Application”. The New Application **will have the word “Required” by fields that are required**
  - ii. The application may consist of two address forms titled “Address Form” and “Additional Address Form”
- c. Out of State New Enrollment Applications with claim Forms such as CMS1500 and UB04
  - i. The first page of a New Enrollment Application is titled “Virginia Medical Assistance Program Provider Enrollment Application”. The New Application **will have the word “Required” by fields that are required**
  - ii. The application may consist of two address forms titled “Address Form” and “Additional Address Form”
  - iii. Out of state applications that have claim forms such as CMS 1500 or UB04 remains with the application and is placed at the end of the application
  - iv. Verify that Section I of the Primary Servicing Address field has a state code other than **VA**
- d. Missing Information Letters
  - i. Missing Information Letters are identified by a DMAS letter requesting information to complete the Enrollment Application process within 15 or 30 days. The 15 day request will have the words **2<sup>nd</sup> Request** noted in the heading of the letter
- e. Disclosure of Ownership & Control Interest Statement
  - i. The first page of the Disclosure of Ownership & Control Interest Statement is titled “Disclosure of Ownership & Control Interest Statement”. The second page begins with “Section III. Criminal Offenses 42 C.F.R.”. Additional pages include documents titled Disclosure of Ownership & Control Interest Statement with listing of names, addresses and/or business locations
- f. Mailing Suspension Request/Signature Waiver/Pharmacy POS Form
  - i. Form titled “Mailing Suspension Request, Signature Waiver and Pharmacy Point-of-Sale” at the top.
- g. Reassignment of Benefits Form
  - i. Form titled “Reassignment of Benefits Form”.
- h. Participation Agreement

- i. Form title is "Participant Agreement".
- i. License/License Renewals
  - i. The license is enclosed by the provider and comes in different forms such as a letter with a state seal or copy of license certificate. A License Renewal letter will have Provider Enrollment Services written under the Commonwealth of Virginia seal.
- j. Electronic Funds Transfer Informational Letter
  - i. Instructions regarding Electronic Funds Transfer. This form may or may not come back.
- k. Attestation Form
  - i. The Attestation Form is titled "Certification and Attestation for Physician Primary Care Rate Increase Form-Free for Service"
- l. Electronic Funds Transfer Application
  - i. Electronic Funds Transfer Application Form titled "Electronic Funds Transfer Application". This form may have a voided check attached. **Do not log on check log and place into the lock box. Voided checks are part of the application process.**
  - ii. The Electronic Funds Transfer Application may include the instructions page. If included, place behind the Electronic Funds Application.
- m. Provider Service Center Authorization (EDI)
  - i. Form titled "Provider Service Center Authorization".
- n. Claim Forms
  - i. CMS1500, UB04 etc.
- o. Reject Letters
  - i. Provider Letter indicating rejection into the Virginia Medicaid program
- p. EDI Customer Service Authorization Forms
  - i. Form titled " Provider Service Center Authorization"
- q. *Duplicate 1099*
  - i. *Letter requesting a copy of the original 1099 form*
- r. *Provider Maintenance*
  - i. Documents not listed that come in without an application is considered supporting documentation
- s. Termination Letters
  - i. Termination letters are identified by wording such as Disassociate, Deceased and No Longer associated noted in the body of the letter
- t. Backend Scanning Documents
  - i. Backend scanned documents come directly from PES. They are either hand delivered directly to the Mailroom or picked up from the Backend Scan basket in

the PES unit and processed as either Enrollment Applications, Maintenance or Site Visit Documents

## Batching

### 1. Document Types

#### a. New Enrollment Application Packets

- i. New Enrollment Applications will have the word "Required" by fields that are required
- ii. New Enrollment applications can be received by mail or fax
- iii. If Application consist of a Fax Cover sheet or Provider Type page, move to the back of the packet
- iv. Place Enrollment Form Instructions in the waste bin
- v. If an Application/Revalidation Check or Credit Card Payment form is within the Application, replace it with A Provider Enrollment Application Fee form
- vi. If multiple applications are submitted within one faxed document, separate by Provider Name or NPI and process individually
- vii. Insert Document Separator sheet at the end of each Enrollment Application Packet
- viii. Crisscross each Enrollment Application Packet after prepping
- ix. Batch Enrollment Application Packets in groups of 10 or less
- x. Place a "New Application Batch Cover Sheet" on top of each batch. New Application cover sheets are always in a green color which is used to identify New Applications to be Data Entered
- xi. Stage for scanning
- xii. After scanning, log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- xiii. Stage batches in the Mailroom for Data Entering

#### b. Out of State New Enrollment Applications with claim forms such as CMS1500 and UB04

- i. Out of State New Enrollment applications can be received by mail or fax
- ii. If Application consist of a Fax Cover sheet or Provider Type page, move to the back of the packet
- iii. Place Enrollment Form Instructions in the waste bin
- iv. If an Application/Revalidation Check or Credit Card Payment form is within the Application, replace it with A Provider Enrollment Application Fee form
- v. If multiple applications are submitted within one faxed document, separate by Provider Name or NPI and process individually
- vi. Insert Document Separator sheet at the end of each Enrollment Application Packet

- vii. Crisscross each Enrollment Application Packet after prepping
- viii. Batch Enrollment Application Packets in groups of 10 or less
- ix. Place a “**New Out of State Application**” cover Sheet” on top of each batch. Out of State New Application cover sheets are always in a green color which is used to identify Out of State New Applications to be Data Entered
- x. Fill in the cover sheet information for prepping
- xi. Stage for scanning
- xii. After scanning, log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- xiii. Deliver to PES for Enrollment and Data Entry of the new Applications.

**c. Missing Information Letters**

- i. Missing Information Letters can be received by mail or fax and will have a Provider Application Tracking Number on each letter
- ii. If a Fax Cover sheet is submitted, move to the back of the packet
- iii. If a Missing Information Letter comes in by itself, process as a Provider Maintenance Document
- iv. If an Enrollment Application Packet is attached to a Missing Information Letter place the Missing Information Letter on top of the Enrollment Application Packet and process as a Missing Information Letter
- v. Insert the Document Separator sheet behind each set of documents
- vi. Crisscross each set of documents after prepping
- vii. Batch in groups of 10 or less
- viii. Place a “Missing Information” **batch** Cover sheet on top of each batch
- ix. Fill in the cover sheet information for prepping
- x. Stage for scanning
- xi. After scanning, log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- xii. Deliver batches to PES for storage

**d. Reject Letters**

- i. **License Expiring or Renewal Reject Letter**
- ii. Reject letters can be received by mail or fax.
- iii. If a Fax Cover sheet is submitted, move to the back of the packet.
- iv. If a Reject letter comes in by itself, process as a Provider Maintenance Document.
- v. Cover old ICN numbers on the first and last document of the Enrollment Application Packet.
- vi. If an Enrollment Application Packet is attached to a Reject Letter move the Reject Letter to the back of the Enrollment Application Packet and process as an Enrollment Application.

- vii. If a license is attached to a License Expiring or Renewal Reject letter, the letter stays on top and is processed as a License document.
- viii. Insert the Document Separator sheet at the end of the Enrollment Application Packet.
- ix. Stage for scanning.
- x. Log the Receipt Date, Document Type, Batch Number, Batch Count, and Initials into the PES Work Log found on the Z drive.
- xi. Deliver to the PES department.

**e. Terminations**

- i. Termination letters can be received by mail or fax
- ii. If a Fax Cover sheet is submitted, move to the back of the packet
- iii. Briefly check the letters for wording such as Disassociate, Deceased and No Longer associated noted in the body of the letter to determine that it is a Termination letter
  - i. Insert a Document Separator sheet at the end of each batch
- iv. Batch in groups of 10 or less
- v. Place a "Termination" Batch Cover Sheet on top of each batch
- vi. Stage for scanning
- vii. Log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- viii. Deliver to the PES department

**f. EDI Customer Service Authorization Forms**

- i. EDI forms can be received by mail or fax
- ii. If a Fax Cover sheet is submitted, move to the back of the packet
- iii. Insert Document Separator sheet at the end of each form
- iv. Batch in groups of 10 or less
- v. Place a Batch Cover Sheet on top of each batch
- vi. Stage for scanning
- vii. Log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- viii. Deliver to the Call Center

**g. Duplicate 1099**

- i. Duplicate 1099 letters can be received by fax or mail
- ii. If a Fax Cover sheet is attached, move to the back of the packet
- iii. Verify that the request is for a Duplicate 1099
- iv. Insert Document separator sheet at the end of each letter
- v. Batch in groups of 10 or less

- vi. Place a "Duplicate 1099" Batch Cover Sheet on top of each batch
- vii. Stage for scanning
- viii. Log the Receipt Date, Document Type, Batch Number, Batch Count, and Initials into the PES Work Log found on the Z drive
- ix. Deliver to the PES department

**h. License/License Renewals**

- i. Licenses and Renewals can be received by fax or mail
- ii. If a Fax Cover sheet is attached, move to the back of the packet
- iii. Screen each License Renewal making sure all documents belong together
- iv. If multiple License or License Renewals are submitted within one faxed document, separate by Provider Name or NPI and process individually
- v. Some Licenses will come in with the NPI numbers written on them and others will use a fax cover sheet to reference NPI numbers for licenses mailed or faxed. Place Document Separator sheet at the end of each license
- vi. If License Renewal Letter is on top of a license, leave the letter on top of the license
- vii. Insert the Document Separator sheet at the end of each License Renewal
- viii. Batch in groups of 10 or less
- ix. Place a License Renewal Batch Cover Sheet on top of each batch
- x. Stage for scanning
- xi. Log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- xii. Deliver to the PES department

**i. Attestation Form**

- i. Attestation Forms can be received by mail or fax
- ii. Faxed and Mailed documents can be batched together
- iii. Insert a Document Separator sheet behind each form
- iv. Batch in groups of 30 or less
- v. Stage for scanning
- vi. Log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- vii. Deliver to the PES department

**j. Provider Maintenance**

- i. Provider Maintenance documents can be received by mail or fax
- ii. Provider Maintenance consists of a variety of Provider Updates such as Address Changes, EFT, Revalidation Forms and Correspondence changes

- iii. Insert the Document Separator sheet at the end of each document or set of documents
- iv. Batch in groups of 10 or less
- v. Place a Provider Maintenance Batch Cover Sheet on top of each batch
- vi. Stage for scanning
- vii. Log the Receipt Date, Document Type, Batch Name, Batch Count, and Initials into the PES Work Log found on the Z drive
- viii. Deliver to the PES department

**k. Backend Scanning Documents**

- i. Backend Scanning documents come directly from PES. They are either hand delivered directly to the Mailroom or picked up from the Backend Scan basket in the PES unit. Backend scanned documents are processed as New Enrollment Applications, Maintenance or Site Visit documents. New Enrollment documents are identified with the Letters "EA" coded at the top of the application and Site Visit documents are identified with the letters "SV" coded at the top of the Site Visit form. All other documents are identified as Maintenance documents

1. Backend - New Application – (EA)

- a. Prep as New Applications only if (EA) is coded at the top of the Application
- b. New Enrollment Applications will have the word "Required" by fields that are required
- a. If Application consist of a Fax Cover sheet or Provider Type page, move to the back of the packet
- b. Place Enrollment Form Instructions in the waste bin
- c. If an Application/Revalidation Check or Credit Card Payment form is within the Application, replace it with A Provider Enrollment Application Fee form
- d. If multiple applications are submitted within one faxed document, separate by Provider Name or NPI and process individually
- e. Insert Document Separator sheet at the end of each Enrollment Application Packet
- f. Crisscross each Enrollment Application Packet after prepping
- g. Insert the Document Separator sheet at the end of each document or set of documents
- h. Batch in groups of 25 or less.
- i. Place a red Backend Batch Cover Sheet on top of each batch
- j. Fill in the cover sheet information for prepping
- k. Stage for scanning



1. P.O. Box 26228

- a. Sort envelopes by code in the window at the bottom of the envelope.
  - i. IF the code is equal to "VAMMISCHKRA", open and check to see if a live check is enclosed. Checks that say "This Area is Intentionally Left Blank" are not checks and should not be included as a check. If a check is enclosed, set aside to be logged as an incoming check by logging the receipt date, check number, check amount and Provider/Organization name on the Check Log, insert contents into original envelope and place in the Financial Services lock box
  - ii. Using the chart below, check the remaining envelope codes to determine if they consist of codes that can be shredded

PES Mail codes to be shredded
CPO-493

6.1.1.1	AS0116
6.1.1.2	CPO44801
6.1.1.3	AS0317
6.1.1.4	Commonwealth Martin NO NPI
6.1.1.5	SID 003
6.1.1.6	EPO09206
6.1.1.7	EPO09205
6.1.1.8	AS0119
6.1.1.9	FNO049
6.1.1.10	AS0111
6.1.1.11	CPO04471
6.1.1.12	RSO148
6.1.1.13	SUO053
6.1.1.14	RSO167
6.1.1.15	CPO44704
6.1.1.16	CPO44406
6.1.1.17	FN0048

- iii. Batch in groups of 20 or less
- iv. Place a "Return Mail Batch Cover Sheet" on top of each group of documents
- v. Deliver to the Provider Enrollment Services Department and log the Julian Date and number of envelopes into the PES Tracking Log found on the Z drive

2. PO Box 26803

Sort by NPI vs. Non NPI

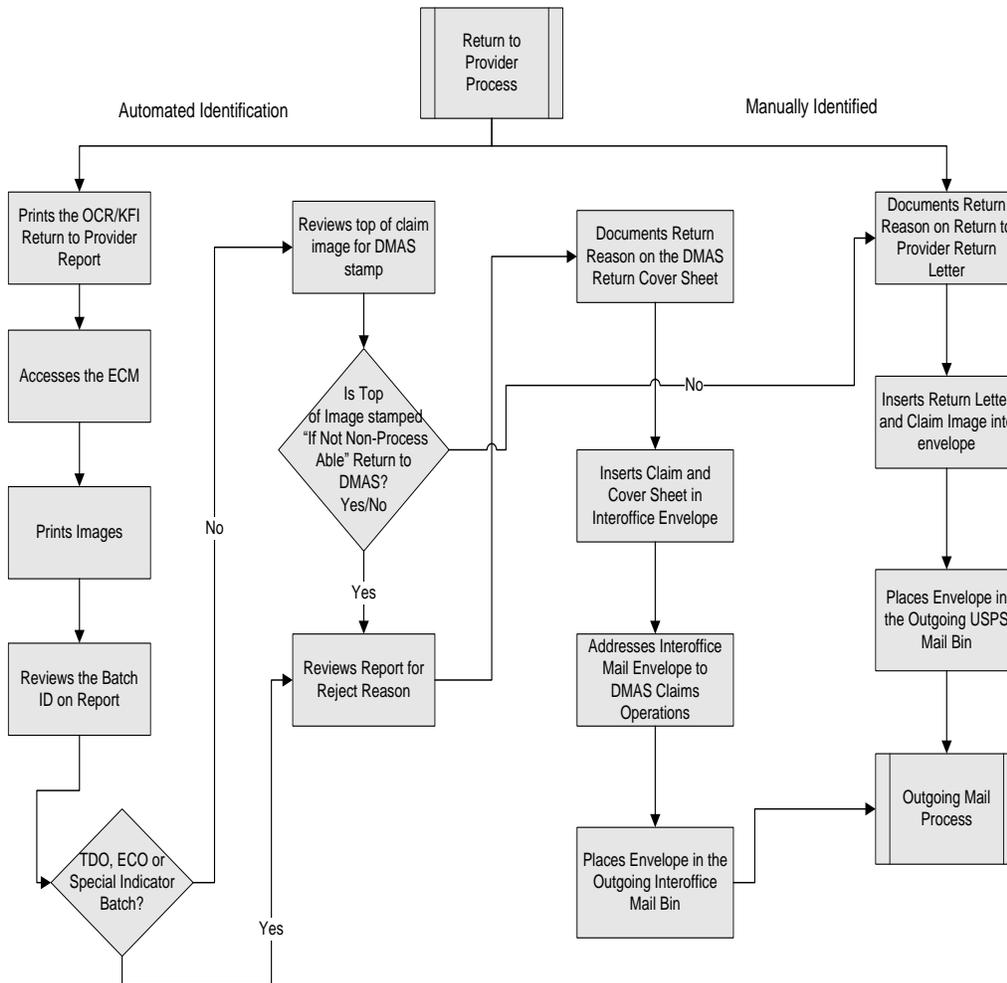
1. NPI
  - a. Count and batch in groups of 20 or less
  - b. Place a "Return Mail Batch Cover Sheet" on top of each group of batched documents
  - c. Deliver to the PES department
2. Non NPI
  - a. Count number of envelopes and Shred

## 4.3. Return to Provider/DMAS

Document Control Specialist manually screens CMS1500, Dental, Pharmacy, UB04, payment requests and Electronic and Direct Data Entry Claim submittal forms to identify those that cannot be processed and therefore returned to the provider or DMAS. In addition, the payment request data capture system is configured with edits to flag payment requests or Electronic and Direct Data Entry Claim Submittal forms that do not meet criteria and are rejected from the process as "Return to Provider" or "Return to DMAS". Prior to returning payment requests, a letter is attached to each payment to indicate the reason(s) for return. See Appendices Section 10.4 letter sample.

Return to Provider/DMAS Workflow

This diagram presents a graphic depiction of the document preparation, screening, and scanning processes.



Return to Provider/DMAS (Manually Screened)

 **SLA (Service Level Agreement): Return all payment requests missing key fields <48 hours after receipt.**

**Procedure:**

1. Payment Requests
  - a. Review the payment request for the DMAS Stamp.
    - i. If the payment request rejected from the process is stamped “If Not Processable Return to DMAS”, go to steps i through l.
  - b. If not stamped “Not Processable Return to DMAS”, go to steps c through f.
  - c. Document on the return to Provider letter the reason(s) for returning payment request to the provider such as:
    - i. Missing or Invalid rendering and/or Billing Provider number(s)
    - ii. Enter all claim information in black ink only
    - iii. Billing information not confined to available space

- iv. Authorized Signature/Date missing
  - v. Claim submitted on an obsolete form
- d. Initial and date (MM/DD/YY) the Return to Provider letter in the applicable fields at the bottom of the form.
- e. Address the envelope to the mailing address on the payment request in the Billing Provider field. On UB04 claims always use the address in block 1.
- i. If the payment request does not have the Billing Provider Address field, return payment request to the return address on the envelope.
  - ii. If the payment request does not have the Billing Provider Address field or Billing Address is not included, use MMIS to lookup the providers billing address using the NPI located on the claim.
  - iii. If the payment request does not have the Billing Provider Address field or Billing Address is not included and missing all provider ID's, place payment request into the recycle bin.
- f. Z-fold the letter and documentation.
- g. Insert return letter and payment request into the envelope making sure the Commonwealth of Virginia logo is facing the back of the envelope. See Appendices 10.0 for an example of the return letter.
- h. Place envelope in the Outgoing US Mail bin.
- i. If it is a return to DMAS document, document on the return to DMAS return cover sheet the reason(s) for returning payment request such as:
- i. Missing or Invalid Rendering and or Billing Provider Number(s)
  - ii. Enter all claim information in black ink only
  - iii. Billing Information not confined to available space
  - iv. Authorized Signature/Date missing
  - v. Claim submitted on an obsolete form
- j. Address the interoffice envelope to DMAS Customer Service and batch with the Return to DMAS cover sheet completely filled out.
- k. Insert return letter and payment request into the interoffice envelope. See Appendices 10 for an example of the return letter.
- l. Place envelope in the DMAS Outgoing Mail bin.

## **2. Electronic and Direct Data Entry Claim Attachment Submittal Forms**

- a. As of 4/4/12, all Electronic and DDE Claim Attachment Submittal forms with the following conditions can be shredded:
- i. Claim submission or Electronic forms submitted without an ACN with attachments
  - ii. Claim submission or Electronic forms submitted without an attachment
  - iii. Multiple claim submission or Electronic forms attached together with no documentation

## 4.4. Reprocess Claims Procedure

### Procedure:

1. All documents that need to be reprocessed are delivered by the Claims Department with a specific timeline for completion to the mailroom team lead.
2. The batches are then re-prepped and reprocessed according to the batch cover sheet provided by the Claims Department.
  - a. All documents should be prepped in accordance with sections 4.2.1 – 4.2.9
3. The batches are then given to the operator of Scanner A and the timeline of completion for reprocessing is communicated.
4. Once scanned, each new ICN and batch number is recorded on the reprocess cover sheet and processed in accordance with sections 4.2.1 – 4.2.9.
5. The Claims Department is then contacted for pickup of batches.

# 5. Imaging Procedures

Document Control sorts and batches paper documents by scanner job type. The Image Technician scans paper documents using the appropriate predefined job names. The predefined scanner job names are recognized by the system and routes images to the next processing stage. In addition, imaged documents are stored in the Enterprise Content Manager for archive and retrieval.

## 5.1. Scanning Documents



**SLA (Service Level Agreement): Image and Index Provider Enrollment Documents <2 business days from receipt.**

### Datacap Procedure:

1. Click on the ██████████ MCLAIMS icon to launch the Taskmaster Scan application.
2. Click on the Scan icon to display the Select Job Panel.
3. Review the Scanner Batch Cover Sheet for imaging instructions.
4. Select the appropriate job from the Select Job panel.
  - a. If batch cover sheet is Provider Class, Financial Class or Member Class then select Index Scan
  - b. If batch cover sheet is Claims Class and Document Types are Electronic Attachments, Assessments, TAD's or Claims Correspondence then select Index Scan
5. Enter the Prep ID found on the Batch Cover Sheet.
6. Always select 5 as the Priority from the Start Batch Panel drop down menu.
7. Select the appropriate Received Date from the Start Batch Panel drop down window.
8. Verify all selections are correct.
9. Place documents on scanner feeder.
  - a. Documents must be faced up
  - b. Top of form must be placed on the right guide of the scanner
10. Click on the Scan button located at the bottom of the Start Batch Panel to start scanner.
11. Record batch type, prep ID, starting document number, ending document number, batch number, and any additional comments on to the Datacap Scanning Log.
12. Click on the Finish button located at the bottom of the Batch Panel window.
13. Prepare documents for additional processing.
  - a. If document type is TAD (Turnaround Document), complete the Incoming TAD Document cover sheet and stage for delivery to Claims processing unit
  - b. If Document Class is Provider, complete the Incoming PES Document cover sheet and stage for delivery to PES or the staging area in the mailroom

- i. New Enrollment Applications – Stage in the mailroom for keying
    - ii. Out of State New Enrollment Applications – Deliver to PES for keying and enrollment
    - iii. Missing Information Letters – Deliver to PES for storage
  - c. If document type is not ER Pend Letter go to step 14
- 14. File paper documents into the retention box.
  - a. Claim documents must be filed together in document number sequence in a retention box. Document types include Electronic Attachments and Direct Data Entry Attachments
  - b. Document types such as Electronic Attachments, Claims Correspondence, Member and Financial are stored together in a retention box.
  - c. New and Out of State Applications, are stored in retention boxes for 30 days.
- 15. At the end of shift, make a copy of the scanning log, give the copy to your supervisor and place original copy into the scanner binder.



**SLA (Service Level Agreement): Receive, control, assign a unique ICN, image, transfer to MMIS and adjudicate all paper payment requests and their attachments or any other associated claims documents within 72 hours of receipt.**

List of Job Names for Datacap	
Scanner Job Names	Invoice Type
Provider	Enrollment Applications, Licenses, Maintenance, EDI Documentation, Physician Rate Increase Program Certification, Attestation Forms, Missing Information Letters and Backend Scanned documents
Claims	Full Assessments, Short Assessments, Electronic Attachments, Direct Data Entry Attachments and Turnaround Documents
Finance	Checks and 1099's
Member	Member ID Cards

**Procedure:**

All London batches will require a Stack Header form which will be created by the Lead or the Leads backup prior to Sorting and Screening. The Stack Header replaces having to select a scanner Job Name from the scanner. In the event the wand used to scan the Stack Header barcode is not working properly, the scanner operator has the ability to key the barcode number (batch name) in at the time of scanning.

## 5.2. Creating Stack Headers

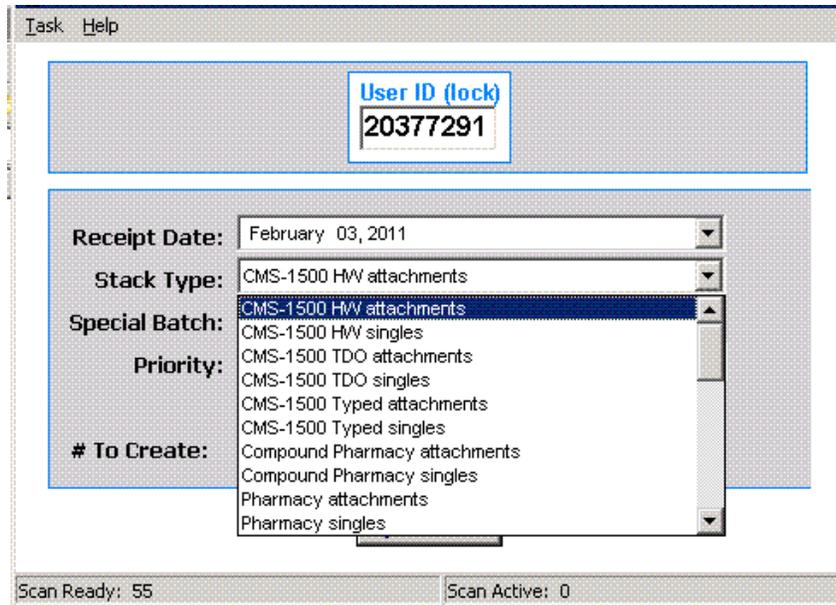
### Procedures:

1. On the XXXXXXXXXX, enter your User ID.

The screenshot shows a web application window with a title bar containing 'Task' and 'Help'. The main content area is a form for creating stack headers. At the top, there is a 'User ID' input field. Below it, there are four dropdown menus: 'Receipt Date' (set to 'February 03, 2011'), 'Stack Type' (set to 'CMS-1500 HW attachments'), 'Special Batch' (set to 'No'), and 'Priority' (set to 'No'). Below these is a '# To Create' input field. A 'Submit' button with a green checkmark is positioned below the form. At the bottom of the window, a status bar displays 'Scan Ready: 55' and 'Scan Active: 0'.

**NOTE:** Left-click the User ID to lock it so that you don't have to enter your ID for each header you create.

2. Select the correct Receipt Date Process Date from the drop-down list.
3. Choose the Stack Type you want to create from the drop-down list.



## 5.3. Stack Types

Stack Types	
Compound Pharmacy Attachments	•
Compound Pharmacy Singles	
CMS-1500 CO Attach	
CMS-1500 CO ECO Attach	
CMS-1500 CO ECO Singles	
CMS-1500 CO HW Attach	
CMS-1500 CO HW Singles	
CMS-1500 CO Singles	
CMS-1500 CO TDO Attach	
CMS-1500 CO TDO Singles	
CMS-1500 ECO Attach	
CMS-1500 ECO Singles	
CMS-1500 HW attachments	
CMS-1500 HW singles	
CMS-1500 TDO attachments	
CMS-1500 TDO Single	
CMS-1500 TDO singles	
CMS-1500 Typed attachments	
CMS-1500 Typed singles	
Rescan CMS-1500 Attachments	
Rescan CMS-1500 Single	

Stack Types	
Pharmacy attachments	
Pharmacy singles	
UB04 ECO attachments	
UB04 ECO Crossover Attach	
UB04 ECO Crossover Multi	
UB04 ECO Crossover Single	
UB04 ECO MultiPage Attach	
UB04 ECO MultiPage Claim	
UB04 ECO Singles	
UB04 HW attachments	
UB04 HW Crossover attach	
UB04 HW Crossover Multi	
UB04 HW MultiPage Attach	
UB04 HW MultiPage Claim	
UB04 HW singles	
UB04 HW singles Crossover	
UB04 TDO attachments	
UB04 TDO Crossover Attach	
UB04 TDO Crossover Multi	
UB04 TDO Crossover Single	
UB04 TDO MultiPage Attach	
UB04 TDO MultiPage Claim	
UB04 TDO singles	
UB04 Typed attachments	
UB04 Typed Crossover attach	
UB04 Typed Crossover Multi	
UB04 Typed MultiPage Attach	
UB04 Typed MultiPage Claim	
UB04 Typed singles	
UB04 Typed singles Crossover	
•	

### Special Batches/Priority

1. **Special Batch and/or Priority** – If a batch is a 'Special Batch' and/or a 'Priority', choose Y from the drop down lists. \*\*Note batch can be both a 'Special Batch' and a 'Priority' \*\*
2. Enter the number of stack headers you want to create for the document type and click Submit.

=

3. The stack headers will print.
4. Place one stack header on top of each stack of documents by document type (CMS, UB04's, etc.)
5. The stacks are now ready to be scanned.

## 5.4. Naming Conventions

The documents are identified at each level by the use of Stack Header bar-coded sheets. Using the mailroom client, these headers are automatically printed by the program and then manually applied to each stack of documents prior to scanning.

## 5.5. Stack Header Naming Convention:

**SHXNYJJJM1234**

Where:

S =	Stack
HXN =	DocType
YY =	Year
JJJ =	Julian Date
M =	Media Type
Four-digit Stack Sequence Number	

- Once the documents are scanned into the system, the Batch Build program creates the batches.

## 5.6. Batch Naming Convention:

**HXNYYJJJM12345**

Where:

HXN =DocType  
YY = Year  
JJJ = Julian Date  
M = Media Type  
Five-digit Batch Sequence Number

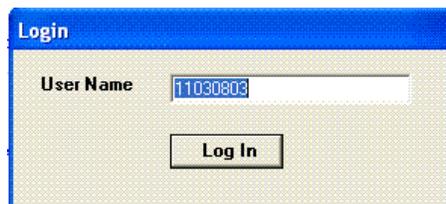
## 5.7. Scanning

The scanning process begins with the collection of document stacks ready for scanning by the Scanner Processor. Each stack of documents is placed in the 'Ready Scan' area. Both sides of the documents are scanned and the images are checked during the Scanning process,

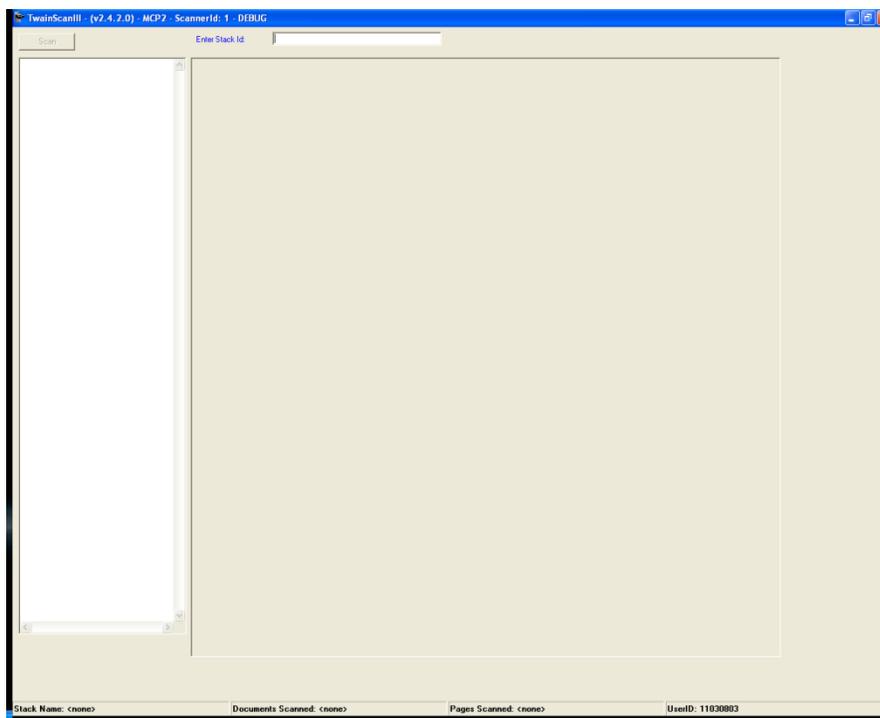
Images are then released and routed by the system to the Data Entry unit via SFTP, in Monticello, KY.

## 5.8. Start-Up/Scanning a Stack

1. Turn the two power switches on the Scanner to the 'On' position, followed by the monitor and hard-drive.
2. On the Scanner PC, enter your WIN ID (8-digit) on the Password window and press Enter or click Log in.



3. Double-click on the  icon.



4. Click the scan button in the upper left-hand corner.
5. Use the wand to scan the barcode found on the stack header.
6. Insert and Scan the Stack of documents (scanner writes to an assigned drive).

7. The System assigns and endorses a unique Document Control Number (DCN) to each document scanned.

## 5.9. When Finished Scanning a Stack:

1. After scanning the stack, the system asks 'Do you want to continue scanning? Yes or No'. Press Y(es) or N(o) to proceed.
2. System then asks 'Do you want to Post Stack? Yes or No' to proceed.

**CAUTION:** DO NOT POST (COMPLETE) a stack if there is a paper jam, or other problem with scanning the stack.

- Resolve the issue (remove missed staples, etc.) to enable the stack to be fed through the scanner successfully.
- Stop the scanner, fix the problem, and re-scan the Stack, as outlined below.

## 5.10. Re-Scanning a Stack

1. If the scanner errors out and the stack needs to be rescanned, remove the paper from the scanner, re-prepare (fix the problem, i.e., remove miss staples, etc.) and Re-wand the Header Sheet under the barcode reader.
2. If you receive an error, contact the Supervisor to check the workflow.
3. The Supervisor will need to know which stack is having issues.
4. Provide the Stack name to the Supervisor, which is listed at the top of the Stack Header.
5. If the supervisor finds that the Stack is **Active** in the Scan tasks, the Supervisor must use the [REDACTED] program to set the stack back to "**Ready**" before another stack can be scanned.

## 5.11. Shut-Down Procedures

1. To shut down the Scanner, first close all windows (icons) you have open.
2. Next, click on the Start button at the bottom left corner of your screen and select Shut Down.
3. Before you click on OK and totally shut down, you must turn the two switch buttons on the Scanner to the "Off" position.
4. Then click on OK; the message 'It is Now Safe to Turn off Your Computer' returns.
5. Turn off the monitor and hard-drive to complete the shutdown.

## 5.12. Storing Scanned Documents

Once the document stacks are scanned they are placed in a storage box, which is posted with the Batch Number, Process Date, and the beginning and ending DCN numbers.

# 6. Image Quality Check

## 6.1. Viewing Images

Images are viewed from ECM to ensure quality images are stored for retrieval at a later time. Problem images are printed and attached to the log for further research and possible rescanning or reprocessing which will result in quality images being stored correctly in ECM or payment of a claim that did not process due to the incorrect prepping. The Mailroom Lead controls which days logs are worked to ensure timely shredding of claims.

### Procedure:

From ECM, access the first, middle and last image of each batch on the logs identified in Section 10 using the range of ICN's listed beside each batch name. Always view the comments column for notes of missing ICN's.

#### 1. Validate Batch Name Matches Stored Claim Type

- a. If batch name ends with an "N", claims stored should be singles and only one claim should be displayed when the image is viewed in ECM
- b. If batch name ends with an "A", each stored claim should have at least one attachment and all attachments should have the same ICN as the claim. Stroll thru the attachments to validate that multiple claims are not stored as attachments. There will be times when a claim will appear as the attachment, when this occurs and it is not clear that it should be an attachment, see the Mailroom Lead.
- c. If the first two characters of the batch name = UC, verify that the word "Crossover" is coded in block 30 of the claim. If not, notify Mailroom Lead immediately.
- d. If the first three characters of the batch name = UCM, verify that the word "Crossover" is coded in block 30 of the first claim and that there are multiple claims (up to 5) with the same ICN. If not, notify Mailroom Lead immediately.
- e. If the first two characters of the batch name = U4, verify that the word "Crossover" is **not** coded in block 30 of the claim. If coded, notify Mailroom Lead immediately.
- f. If the first three characters of the batch name = U4M, verify that the word "Crossover" is **not** coded in block 30 of the claim and that there are multiple claims (up to 5) with the same ICN. If not, notify the Mailroom Lead immediately.
- g. If the first two characters of the batch name = UT, verify that a "T" is coded in block 37 of the claim. If not, notify the Mailroom Lead immediately.
- h. If the first two characters of the batch name = UE, verify that an "E" is coded in block 37 of the claim. If not, notify the Mailroom Lead
- i. When the batch names do not match the claim types that are stored, view the ICN's forward and backwards to verify where the problem started and ended. Print the problem images and attach them to the control log, identify the batch name(s) of the problem claims with an asterisk beside the batch and attach the printed images to the log for further research which includes pulling the original claims for possible rescan and or reprocessing.

## **2. Validate Keyed ICN Matches ICN on the Stored Image**

- a. Verify keyed ICN matches ICN on the stored image. If it matches, view next ICN
- b. If they do not match, verify that the correct ICN was keyed. If it still does not match, view the ICN's forward and backwards to verify where the problem started and ended. Print the problem images and attach them to the control log, identify the batch name(s) of the problem claims with an asterisk beside the batch and attach the printed images to the log for further research which includes pulling the original claims for possible rescan and or reprocessing.

## **3. Viewable Images**

- a. Ensure all images (claim and attachments) are viewable.
- b. If not, view the ICN's forward and backwards to verify where the problem started and ended. Print the problem images and attach them to the control log, identify the batch name(s) of the problem claims with an asterisk beside the batch and attach the printed images to the log for further research which includes pulling the original claims for possible rescan and or reprocessing

Once the Quality Control process is complete for a particular day's log, forward the logs back to the Mailroom Lead for review and action to be taken on problem claims.

# 7. Image Indexing Procedures

Document images are archived in the Enterprise Content Manager (ECM) for retrieval and viewing. Properties are assigned to images before archiving in the ECM. The image properties are used for search criteria to retrieve and view images.

## Procedure:



**SLA (Service Level Agreement): Image and Profile Provider Enrollment Documents <2 business days from receipt.**

1. Click on Datacap Taskmaster Web located on the admin's desktop to display the Login Screen
2. Enter your User ID and Password, then click the Login button to display the Operations menu
3. Click the Indexing Process option to display the available batches
4. Click on the first batch ID listed with status Pending to display the data entry panel and first image to index
5. Review document to identify document type.
6. Click on the Document type drop-down menu and select the appropriate document type.
7. Review index properties listed on the data entry panel.
  - a. Pink highlighted fields are required
8. Review document image for property values listed on the data entry panel.
9. Enter the property values in the appropriate data entry fields.
10. If the Provider Name on the Main Page is not readable key "unknown" in the Provider Name block.
  - a. Provider Name – unknown
11. If the Main Page appears to be processed incorrectly, follow the steps below to reject the documents for review and possible reprocessing.
  - a. Key "unknown" in the Provider Name block
  - b. Key the Provider NPI number as "1234567890"
  - c. Print the document, write the batch number, ICN (If available) and the type of document it is at the top of the printed document along with the words "Please Delete" and place in the basket that is staged for reprocessed documents
12. Click the Submit button to complete and display next image.
13. Repeat steps 5 through 12 until all images within batch is complete and pop-up displays that Batch is complete
14. Click the OK button to complete batch to return to the available batch listing.
15. Repeat steps 5 through 12.

## 7.1. Property Values and Data Entry Instructions – Assessments

Property Name	Property Description	Data Entry Instructions
Document Type	Description of document	Select “Assessment” from the drop-down menu.
ICN	Image Control Number	Auto-populated by system.
NPI	National Provider Identifier	Enter the NPI from the first page of the assessment. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Provider Name	Enter the provider name from the first page of the assessment which is located above the provider number. If the information is not available on line one, use information from line 2. If you have a provider number but no provider name, check through the trailing pages to find the provider name. If not found check MMIS. Do not include dashes, slashes or symbols.

## 7.2. Property Values and Data Entry Instructions – Turnaround Documents

Property Name	Property Description	Data Entry Instructions
Document Type	Description of document	Select “Turnaround Document” from the drop-down menu.
ICN	Image Control Number	Auto-populated by system.
ACN	Assessment Control Number	Enter the ACN number from the first page of the document. If you encounter a document that says VIRGINIA MEDICAID TRANSACTIONS ERRORS INQUIRY, the ACN number will be coded to the left. Do not include dashes, slashes or symbols.
Facility Name	Facility Name	Enter the Facility Name from the first page of the assessment. If you encounter a document that says VIRGINIA MEDICAID TRANSACTIONS ERRORS INQUIRY, Check through the trailing pages to find the provider name.

7.3. **Property Values and Data Entry Instructions  
– Electronic and Direct Data Entry Claim  
Submitted Attachments**

<b>Property Name</b>	<b>Property Description</b>	<b>Data Entry Instructions</b>
<b>Document Type</b>	<b>Description of document</b>	<b>Select “Electronic Attachment” from the drop-down menu.</b>
<b>ACN</b>	<b>Attachment Control Number</b>	<b>Key the ACN number as it appears on the first sheet of the Electronic Attachment or Direct Data Entry Claim Submitted form. It consists of the patient acct #, date and sequence number. Key this as one number with no dashes slashes or symbols, Alpha characters are valid and should be keyed. If no ACN is coded on the document, follow the steps in section 7 number 11 to reject a document</b>
<b>Member Id</b>	<b>Member ID</b>	<b>Enter the Member ID from the first page of the Direct Data Entry Claim Submitted attachment.</b>
<b>NPI</b>	<b>National Provider Identifier</b>	<b>Enter the NPI from the first page of the Electronic Attachment or Direct Data Entry Claim Submitted form. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.</b>
<b>Provider Name</b>	<b>Provider Name</b>	<b>Enter the Provider Name from the first page of the Electronic or Direct Data Entry Claim Submitted form.</b>

## 7.4. Property Values and Data Entry Instructions – Enrollment Package

Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select "Enrollment Application" from the drop-down menu.
NPI	National Provider Identifier	Enter 10-digit value found on first page of application. If you have a group name and an individual name, glance at the participation agreement to see if NPI information is different. If the NPI on participation agreement is different key it as the NPI number. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Name of Provider requesting service	Enter Provider Name- If this is a group application use group name. If this is an individual application
Application Tracking Number	Number use to track original receipt date	Bypass
Sub Class	Request Type	Select "Enrollment" from the drop-down menu. Enrollment Applications should have one Main Page followed by any number of Trailing Pages.
SSN/EIN	Provider Social Security Number or Employer Identification Number	Enter 9-digit value. If this is an individual application, use SS#. If this is a group application, use EIN# Do not include dashes, slashes or symbols.

## 7.5. Indexing Property Values and Data Entry Instructions – Missing Information Letter

Property Name	Property Description	Data Entry Instructions
Document Type	Missing Information Letters	Select “PROV OTHER” from the drop-down menu.
NPI/API	National Provider Identifier	Enter 10-digit value. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Name of Provider requesting service	Enter Provider Name. If no name is available or readable, key the word “unknown”.
Application Tracking Number	Number use to track original receipt date	Key the alpha/numeric number coded beside (RE:) of the Missing Information Letter
Sub Class	Request Type	Select “Enrollment” from the drop-down menu.
SN/EIN	Provider Social Security Number or Employer Identification Number	Enter 9-digit value. Do not include dashes, slashes or symbols. If this is Group EDI use the EIN number, if it is for an individual use the SSN.

## 7.6. Property Values and Data Entry Instructions – EDI Documentation

Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select “EDI” from the drop-down menu.
NPI	National Provider Identifier	Enter 10-digit value. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Name of Provider requesting service	Enter Provider Name.
Application Tracking Number	Number use to track original receipt date	Bypass
Sub Class	Request Type	Select “Enrollment” from the drop-down menu.
SSN/EIN	Provider Social Security Number or Employer Identification Number	Enter 9-digit value. Do not include dashes, slashes or symbols. If this is Group EDI use the EIN number, if it is for an individual use the SSN.

## 7.7. Property Values and Data Entry Instructions – Provider Maintenance

Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select “Maintenance” from the drop-down menu. This is used for any form not easily identified. Things such as address changes fall into this category. This is also used if you have just a single document as a Main Page within a batch.
NPI	National Provider Identifier	If provided enter 10-digit value. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Name of Provider requesting service	Enter Provider Name. If no name is available or readable, key the word “unknown”.
Application Tracking Number	Number use to track original receipt date	Bypass
Sub Class	Request Type	Select “Enrollment” from the drop-down menu.
SSN/EIN	Provider Social Security Number or Employer Identification Number	Enter 9-digit value. Do not include dashes, slashes or symbols. If this is Group EDI use the EIN number, if it is for an individual use the SSN.

## 7.8. Property Values and Data Entry Instructions – Site Visit

Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select “Site Visit” from the drop-down menu.
NPI	National Provider Identifier	Enter 10-digit value, if provided. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Name of Provider requesting service	Enter Provider or Business Name. If no name is available or readable, key the word “unknown”.
Application Tracking Number	Number use to track original receipt date	Bypass
Sub Class	Request Type	Select “Enrollment” from the drop-down menu.
SSN/EIN	Provider Social Security Number or Employer Identification Number	Enter 9-digit value. Do not include dashes, slashes or symbols (if provided).

## 7.9. Property Values and Data Entry Instructions – Licenses

Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select “License” from the drop-down menu. This should clearly be a license to practice medicine. If unsure please check with your team lead and/or Claims Manager. If you see a DEA certificate or DEA license choose the Maintenance option and NOT the license option.
NPI	National Provider Identifier	Enter 10-digit value, if provided. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider Name	Name of Provider requesting service	Enter Provider Name. If no name is available or readable, key the word “unknown”.
Application Tracking Number	Number use to track original receipt date	Bypass
Sub Class	Request Type	Select “Enrollment” from the drop-down menu.
SSN/EIN	Provider Social Security Number or Employer Identification Number	Enter 9-digit value. Do not include dashes, slashes or symbols (if provided).

## 7.10. Property Values and Data Entry Instructions – Checks

Property Name	Property Description	Data Entry Instructions
Financial_Document_Type	Check, 1099 or Other	Click on drop down to select Check. This is the usual value.
National_Provider_ID	NPI or API, ten digits	Type number in if available. Enter out of the field if blank or an invalid number is coded
Provider_Name	Name of Provider	Enter Provider Name. If illegible, enter Unknown.
Check_Amount	Amount of check	Enter check amount. Include the decimal point but not the dollar sign.  If the coded data is longer than the space allowed, ignore the enough of the first numbers to ensure all ending numbers are keyed as the check amount.
Check_Number	Check Number	Enter check number. Do not include dashes, slashes or symbols. Do not key leading zeroes. If too long, drop the leading digits.
Check Type	Type of check	Select “Refund-Provider” from the drop-down menu.

## 7.11. Property Values and Data Entry Instructions – 1099’s

Property Name	Property Description	Data Entry Instructions
Financial_Document_Type	Check, 1099, or FIN Other	Click on drop down to select 1099.
Document_Type	Document Description	Select “1099” from the drop-down menu.
National_Provider_ID	NPI or API, ten digits	Found under Account Number on the form, lower left hand corner of form (2 forms per page). Enter 10-digit value. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.
Provider_Name	Name of Provider	Enter Provider Name
Check_Amount	Amount of 1099	Found in Box 6, half way down right side of form (2 forms per page). Include the decimal point but not the dollar sign. If too long to fit in field, drop the leading digits.
Check_Number	None	Leave blank.
Check_Type	Type of check or Document	Select “Weekly Runs” from drop down.

## 7.12. Property Values and Data Entry Instructions – PPC Attestation Form

Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select “PPC Attestation Form” from the drop-down menu.
Sub Class	Request Type	Select “Enrollment” from the drop-down menu.
Provider Name	Name of Provider requesting service	Enter Provider Name. If no name is available or readable, key the word “unknown”. Do not include dashes, slashes or symbols.  Enter out of the field if blank or an invalid number is coded.

## 7.13. Property Values and Data Entry Instructions – Member ID Cards

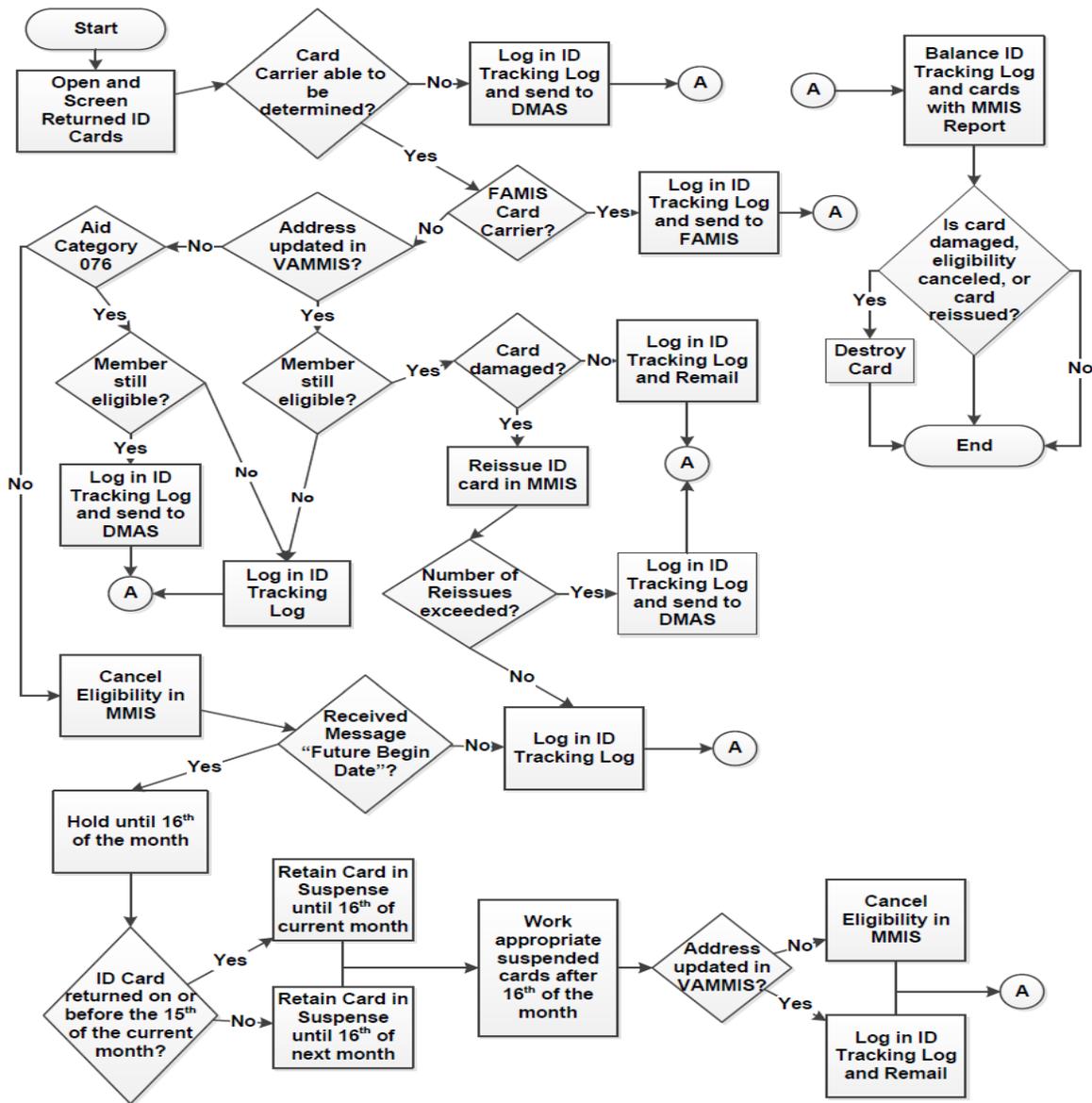
Property Name	Property Description	Data Entry Instructions
Document Type	Document Description	Select “Member ID Card” from the drop-down menu.
DCN	Document Control Number assigned at scanner	Auto-populated by system.
Original DCN	Document Control Number assigned at scanner	Auto-populated by system.
Member ID	Member Medicaid ID Number	Enter 12-digit value.

## 8. Returned Member ID Card Procedures

On a daily basis, all Member ID cards marked as Undeliverable by the Post Office or returned by the enrollees are delivered to the Mailroom. The Undeliverable or returned ID cards are then delivered to the Document Control Unit for processing. The Document Control Unit opens, and researches cards to determine if they are to be re-mailed, reissued if damaged, eligibility cancelled, or forwarded to DMAS or FAMIS for processing. On the following business day the Document Control Unit prints an MMIS generated report with the number of cards reissued and canceled. Document Control compares the MMIS report results to the processing logs and/or cards to verify transactions are accurate.

## 8.1. Returned Member ID Card Workflow

This diagram presents a graphic depiction of the returned Member ID Card screening and processing processes.



## 8.2. Screening Returned Member ID Cards

### Procedure:

1. Open the Returned Member ID Cards Tracking Log file.
  - a. The Returned Member ID Card Tracking Log is located in the shared drive Z:\Claims Services\Mail Room\ID Card Logs-Master, Employee & Verification\Returned ID Card Log.xls.
  - b. Enter the date to Column A above the ID Number block for each date of the month that ID cards were received. The date each employee posts to the log is the date that the cards are being worked regardless of whether or not they were received that day or are carryovers from a previous date.
  - c. The total number of incoming cards corresponding to each date is entered in Column C on the "Totals" line (if no cards were received, a "0" is keyed).
2. Identify if ID Card is issued by DMAS or FAMIS:
  - a. FAMIS ID Cards are identified by RSO201 above the name on the card carrier or have the words printed on the letter carrier "How to use your FAMIS Card"
  - b. DMAS ID Cards are identified by RSO202 above the name on the card carrier or have the words printed on the letter carrier "How to use your Medicaid Card"
3. If it is a FAMIS ID card, follow the steps below. If it is not a FAMIS ID card, go to step 6.
  - a. Update the Returned Member ID Cards Tracking Log by color coding the Member ID Number block (Column A) dark gray , counting the number of FAMIS cards received and entering the card count in the FAMIS block, enter initials and color code the Destroy Date block dark gray.
  - b. Create a stack for FAMIS ID Cards
4. After all cards are screened and logged, all FAMIS cards are placed in an interoffice envelope, addressed to "FAMIS - [REDACTED]" and are delivered by courier each day.
5. Review envelope contents but do not discard envelope until screening and balancing process is complete
  - a. If the returned ID card includes the card carrier, go to step 7
  - b. If the returned card does not include the card carrier and/or original envelope
    - i. Update the Returned Member ID Cards Tracking Log by color coding the Member ID Number block (Column A) dark gray, counting the number of cards without a carrier received and entering the card count in the Card with No Carrier block, enter initials and color code the Destroy Date block dark gray.
    - ii. Create a stack for ID cards received without card carrier and/or original envelope
    - iii. After all cards received are screened and logged, the Member ID Cards without a card carrier are forwarded through interoffice delivery to the DMAS Health Care Services Customer Service Department.
6. Review the envelope contents for an attachment or instructions documented on the ID card carrier.
  - a. If no attachments or instructions, go to Section 8.3 "Researching for New Address, Verifying Eligibility and Aid Category 076"

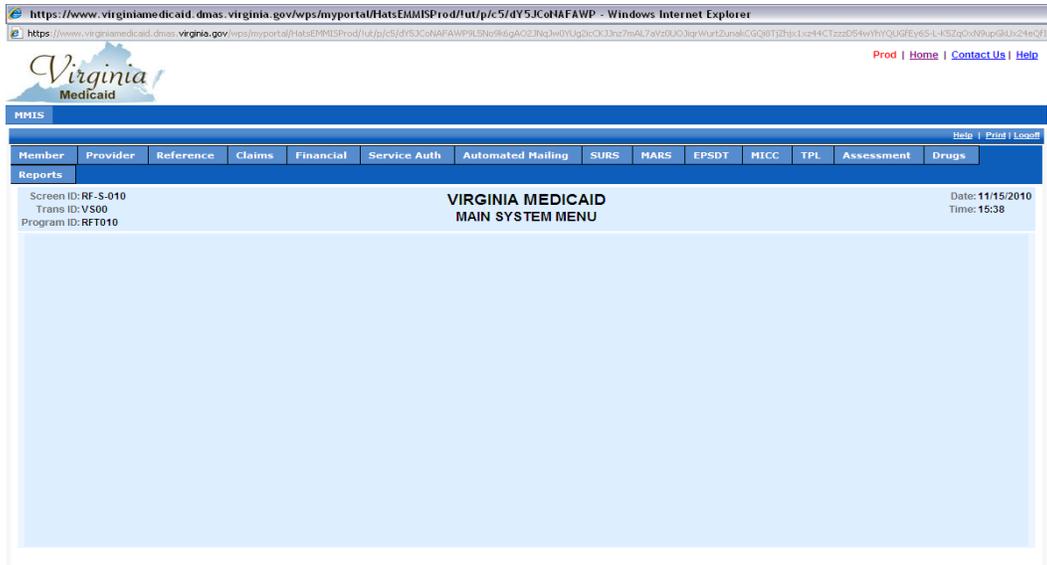
- b. The ID card carrier may have the word "Deceased" and/or an attachment may consist of a death certificate or a note from the member stating the information printed on the card needs to be corrected.
- c. If returned ID card includes an attachment and/or instructions documented on the card carrier, update the Returned Member ID Cards Tracking Log by color coding the Member ID Number block (Column A) dark gray and putting a "1" in the Card with Attach or Instruction block, enter initials and color code the Destroy Date block dark gray. After all cards received are screened and logged, the Member ID Cards with an attachment or instructions are forwarded through interoffice delivery to the DMAS Health Care Services Customer Service Department.

## 8.3. Researching for New Address, Verifying Eligibility and Aid Category 076

### Procedure:

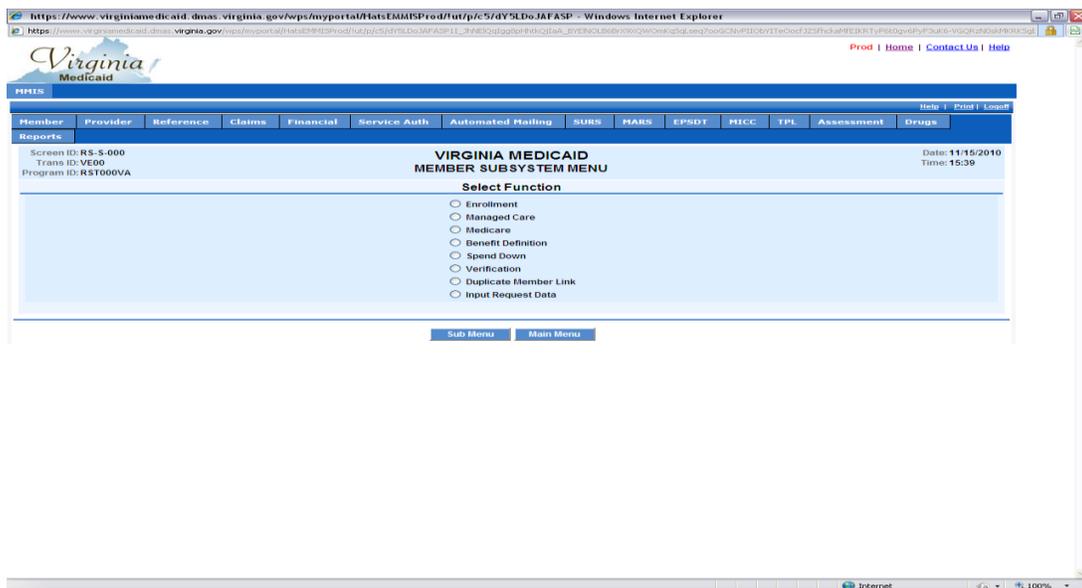
1. From the MMIS Main Menu, click on the Member Subsystem button.

(Screen RF-S-010)



2. From the Member Subsystem menu, click the Enrollment button to display the Enrollment menu screen.

(Screen RS-S-000)



(Screen RS-S-001)

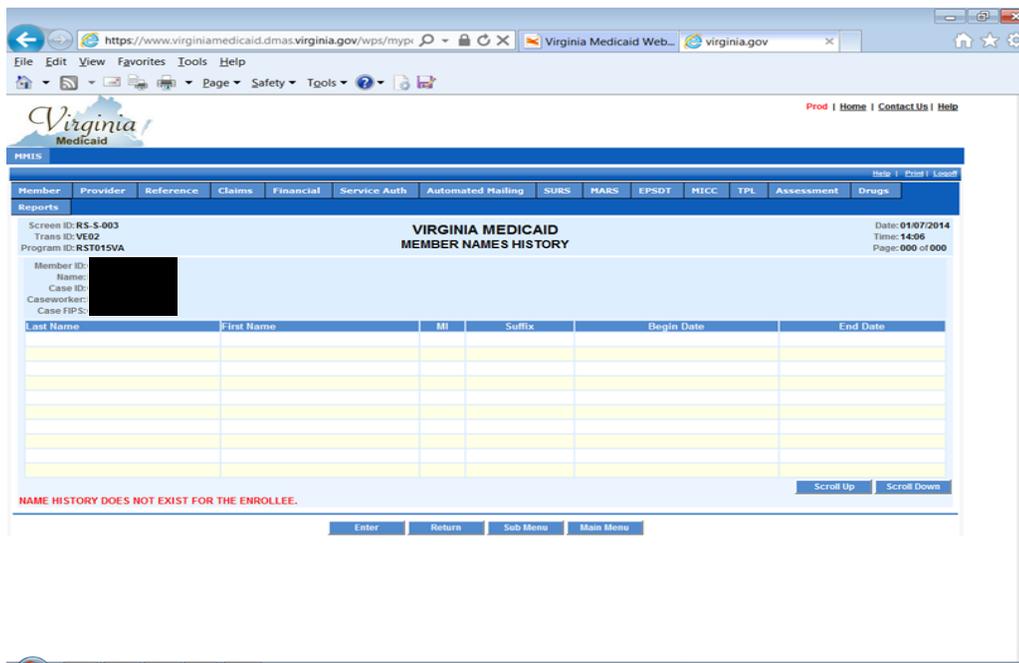
3. From the Enrollment menu, select the Enrollment Type “Member” and Function “Inquiry” options, enter the Member ID, and then hit or click on the Enter button to display the Member Demographics-Inquiry screen.

(Screen RS-S-018)

4. Verify that the name on the card matches the name in MMIS.
  - a. If name matches, go to step 5.
  - b. If the member name is different or spelled differently and the Member ID number was entered correctly, click on the circle next to “View Previous Names” and hit or click on the Enter button.

- c. Verify name(s) on card against the name listed on the "Member Names History" screen (see Screen RS-S-003), Any updates made in MMIS regarding name changes will be shown on this screen. Once validated click Return and proceed with Step 5.

(Screen RS-S-003)



5. Identify card number located at the bottom right of the returned member ID card.
  - a. If the card number is the same as the card number listed in the Sequence # field on the MMIS Member Demographics – Inquiry screen, go to step 6
  - b. If the card number is less than the card number listed in the Sequence # field on the MMIS Member Demographics – Inquiry screen, a new card had been issued before this card was returned. Update the Returned Member ID Cards Tracking Log by putting a "1" in the Already Re-Issued block and enter initials. The Destroy Date block remains blank pending balancing.
  - c. Create a stack for Already Re-Issued Cards until all ID Cards have been worked.
  - d. Click on the Sub Menu button to return to the Enrollment menu.

(Screen RS-S-018)

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/HatsEMMISProd/ut/plc5/dY7dDKNAGAUF - Windows Internet Explorer

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/HatsEMMISProd/ut/plc5/dY7dDKNAGAUF6wwG3q735nCBkWLvRGNRqj\_hDu01cfwJn7mQOFnaFcm7pennEo02RQZhe2Mhw74uw5-Zw8w7U8bp68ASFFRry129Mlfpcs0PatPpCMom30Mm

Prod | Home | Contact Us | Help



MMIS

Help | Print | Logout

Member	Provider	Reference	Claims	Financial	Service Auth	Automated Mailing	SURS	MARS	EPSDT	MICC	TPL	Assessment	Drugs	Reports
--------	----------	-----------	--------	-----------	--------------	-------------------	------	------	-------	------	-----	------------	-------	---------

Screen ID: RS-S-018  
Trans ID: VE18  
Program ID: RST010VA

**VIRGINIA MEDICAID  
MEMBER DEMOGRAPHICS - INQUIRY**

Date: 11/15/2010  
Time: 15:40

Member ID: [REDACTED] Last Name: [REDACTED] First Name: [REDACTED] MI: D Suffix: [REDACTED]  
Case ID: [REDACTED] ADAPT ID: [REDACTED] Caseworker: [REDACTED] Case FIP S: 031 Comments: N  
Aid Category: 081 Benefit Plan: MEDICAID FFS More BP: N Exception Indicator: Absent Parent: N HIPP: HIPP Status: TPL: N  
CMM Restriction Period: CMM Restriction Status:

Relationship to Case Head: 00 Gender: F DOB: 12 23 1970 SSN: [REDACTED] Race: 2 Marital Status: 1 Primary Language: 1  
Cit Status: C Cit Level: GF Identity: V3 Cit / ID Date: 10 2010 SSA Cit Ind: Country: US Entry Date: [REDACTED]  
Same as Case Address: Y Same as Case FIP S: Y Mem FIP S: 031 EDD: [REDACTED] Mother ID: NRF: [REDACTED]  
Phone: [REDACTED] Disability Code: [REDACTED] Disability Onset Date: [REDACTED] Special Ind: DOD: [REDACTED]

Member Address: [REDACTED]  
City: LYNCHBURG State: VA Zip Code: 24501 0000

Suppress ID Card: N

Card Date	Reason	Sequence #	Request #
11/01/2010	1	01	0

View Member FIPS  
  View Previous Names  
  View Previous Address  
  View Aliases  
  View Health Conditions

Pend Claims: Begin Date: End Date: Pend Source:

Scroll Up | Scroll Down

**SELECT AN OPTION AND CHOOSE ENTER.**

Enter	Update	MC Assign	Eligibility	TDO	Financial	Comments	Case	TPL Sum	ID X-Ref	Sub Menu	Main Menu
		ID/CID	Dup Mem	BENDEX	MICC	Absent Parent	VALTC Sum	Cost Eval	Case Sum		

6. Compare address on the Member Demographics screen (RS-S-018) against the address on the card carrier or, if we have attempted to re-mail the card before, against the handwritten address on the envelope. If no new address, go to step 7. If there is a new address, click on the Eligibility button to verify status (see screen RS-S-015).
  - a. If eligibility is still active the cancel date remains blank and the status shows "A" on the top line. Click the Member button to return to the Member Demographics screen and go to step 8.
  - b. If eligibility is cancelled there is already a date in the cancel date column and the status shows a "C" on the top line. Update the Returned Member ID Card Tracking Log by placing a "1" in the Already Cancelled block and enter initials. The Destroy Date block remains blank pending balancing.
  - c. Create a stack for Already Cancelled cards until all cards have been worked.
  - d. Click on the Sub Menu button to return to the Enrollment menu.

(Screen RS-S-015)

Screen ID: RS-S-015  
Trans ID: VE15  
Program ID: RST016VA

**VIRGINIA MEDICAID  
ELIGIBILITY DATA - INQUIRY**

Date: 03/18/2011  
Time: 11:02

Member ID: [REDACTED]  
Name: [REDACTED]  
Case ID: [REDACTED]  
Caseworker: [REDACTED]  
Case FIPS: 700

Consent Date: NO CONSENT  
Income less than or = 100% FPL: Y  
HIPP: [REDACTED]

Comments: N  
Plan First O/R: [REDACTED]  
FPL Begin Date: 01 2011  
HIPP Status: [REDACTED]

Select	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstate Reason	Status
<input type="radio"/>	001	12 13 2010	01 01 2011	12 31 9999	000		000	001	A
<input type="radio"/>	001	12 28 2009	07 01 2010	12 31 9999	005	12 31 2010	000	001	C
<input type="radio"/>	001	12 28 2009	12 01 2009	12 31 9999	012	06 30 2010	000	000	C
<input type="radio"/>	001	12 28 2009	01 01 2011	12 31 9999	071	01 01 2011	000	001	V

DATA DISPLAYED.

Buttons: Enter, Update, Refresh, Member, TDO, Financial, Case, TPL Sum, Comments, Sub Menu, Main Menu, Cost Eval, Case Sum

7. If the Aid Category on the MMIS Member Demographics Inquiry screen (RS-S-018) is coded "076", click on the Eligibility button to verify status and follow the steps below. If not coded "076", click on the Sub Menu button to return to the Enrollment menu and go to section 8.4 Cancelling Eligibility.
  - a. If eligibility is cancelled there is already a date in the cancel date column and the status shows a "C" on the top line. Update the Returned Member ID Card Tracking Log by

placing a "1" in the Already Cancelled block and enter initials. The Destroy Date block remains blank pending balancing.

- i. Create a stack for Already Cancelled cards until all cards have been worked.
    - ii. Click on the Sub Menu button to return to the Enrollment menu.
  - b. If eligibility is still active the cancel date remains blank and the status shows "A" on the top line. Print the Eligibility Data Inquiry screen (RS-S-015) and highlight the "Aid Category 076" and the Status "A" on the printed copy. Update the Returned Member ID Card Tracking Log by placing a "1" in the "Aid Category 076" block, enter initials and color code the Destroy Date block dark gray.
    - i. Paper clip the printed copy to the envelope with the returned member ID card inside and create a stack for Aid Category 076 cards until all cards have been worked.
    - ii. Once all cards have been worked all Aid Category 076 cards with attached screen shots are placed in an interoffice envelope and forwarded to DMAS Healthcare Services to the attention of "Foster Care Coordinator"
    - iii. Click on the Sub Menu button to return to the Enrollment menu
8. Inspect the ID card for damages.
  - a. If ID card is not damaged, re-mail the ID card to the address listed in the Member Demographics – Inquiry screen and update the Returned Member ID Card Tracking Log by putting a "1" in the Re-Mailed block, enter initials and color code the Destroy Date column dark gray.
  - b. Create a stack of cards to be re-mailed until all ID Cards have been worked
  - c. After all cards are worked, fill out a "Metered Mail Count – Code 13" cover sheet for cards to be metered by entering the date and the total count of cards to be re-mailed, secure sheet around the cards and place in the Mail to be Metered basket
  - d. If active, yet damaged, the ID card must be reissued. Go to Section 8.5 "Reissuing New ID Card".
9. Click on the Sub menu button to return to the Enrollment menu.

## 8.4. Cancelling Eligibility

After researching returned ID cards, there may be reasons to cancel member eligibility. ID cards are only cancelled when the address in MMIS matches the address to which the card was sent, the card number matches the last card in their MMIS profile, the Aid Category is not "076" and there are no attachments and/or instructions on the carrier. When eligibility requires cancelling, perform the following steps:

### Procedure:

1. From the Enrollment menu screen (RS-S-001), select the Enrollment Type "Member" and Function "Cancel" options, enter the Member ID and then hit or click on the Enter button to display the Eligibility Data-Cancel screen (RS-S-015)

(Screen RS-S-001)

The screenshot shows the Virginia Medicaid Enrollment Menu screen (RS-S-001) in a web browser. The page title is "VIRGINIA MEDICAID ENROLLMENT MENU". The screen displays the Virginia Medicaid logo and navigation tabs. The main content area contains the following form elements:

- Select Enrollment Type:** Radio buttons for Case, Member, and Case and Member (ADD FUNCTION ONLY).
- Select Function:** Radio buttons for Add, Update, Inquiry, Cancel, Retro Cancel Reinstale, Void, CID Request, Re-set ID Card, ID Card Request, and Plan First Override. A "Re-Issue Reason:" field is also present.
- Case ID:** Text input field.
- Member ID:** Text input field.
- SSN:** Text input field.
- VACIS/ADAPT ID:** Text input field.
- Last Name:** Text input field.
- First Name:** Text input field.
- DOB:** Text input field.
- Telephone Number:** Text input field.
- Suffix:** Text input field.
- Middle Initial:** Text input field.
- Gender:** Text input field.
- HIPP:** Text input field.
- New TDO Enrollee?:** Radio buttons for Yes and No.

At the bottom of the form, there is a red text prompt: "ENTER SELECTION AND FUNCTION." Below this, there is a row of buttons: Enter, Clear Form, Member, Eligibility, TDO, Financial, Case, TPL Sum, ID X-Ref, Override, Sub Menu, and Main Menu. The "Enter" button is highlighted.

2. Verify Member Name is correct.



(Screen RS-S-011)

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/HatsEMMSProd/ut/p/c/5/d/Y7/DolwFEU\_ - Windows Internet Explorer

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/HatsEMMSProd/ut/p/c/5/d/Y7/DolwFEU\_611q3ZaC1QaJR85jHDEgWb8W8BDP\_pwtGz8M9e/megfly0o0HzWEEGLPH4CJfctmcDGCloXCWS2Mto-hwWd0zabokYTR3nie3

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MHIS

Help | Print | Logout

Member Provider Reference Claims Financial Service Auth Automated Mailing SURS MARS EPSDT MICC TPL Assessment Drugs

Reports

Screen ID: RS-S-011  
Trans ID: VEX1  
Program ID: RST011VA

**VIRGINIA MEDICAID**  
**MEMBER BENEFITS - CANCEL**

Date: 11/15/2010  
Time: 15:42

Member ID: [Image]  
Name: [Image]  
Case ID: [Image]  
Caseworker: [Image] Case FIPS: 031

Comments: N  
Income Less Than Or = 100% FPL: Y  
FPL % ST Begin Date: 11 2010

Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Status	Extension Reason	Reinstate Reason
081	10/15/2010	11/01/2010	12/31/9999	012	11/30/2010	C	000	000

Benefit Plan	Exception Indicator	Plan Description	Provider ID	Begin Date	End Date	Change Source	End Reason	Disposition Ind	Disposition Date
01-01-0100		MEDICAID FF	0000000000	11/01/2010	11/30/2010	DF	097	A	10/28/2010

Scroll Up Scroll Down

CHOOSE UPDATE TO ADD/UPDATE DATA.

Enter Update Prov Loc Comments VALTC Sum Return Sub Menu Main Menu

(Screen RS-S-011) – Successful screen after cancelling card

Screen ID: RS-S-011  
 Trans ID: VEX1  
 Program ID: RST011VA

**VIRGINIA MEDICAID  
 MEMBER BENEFITS - CANCEL**

Date: 09/21/2011  
 Time: 11:44

Member ID: [REDACTED]  
 Name: [REDACTED]  
 Case ID: [REDACTED]  
 Caseworker: [REDACTED] Case FIPS: 073

Comments: N  
 Income Less Than Or = 100% FPL: Y  
 FPL % ST Begin Date: 09 2011

Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Status	Extension Reason	Reinstate Reason
091	09/13/2011	09/01/2011	12/31/9999	012	10/31/2011	C	000	000

Benefit Plan	Exception Indicator	Plan Description	Provider ID	Begin Date	End Date	Change Source	End Reason	Disposition Ind	Disposition Date
01-01-0100		MEDICAID FF	0000000000	09/01/2011	10/31/2011	DF	097	A	09/13/2011

DATA DISPLAYED.

Buttons: Enter, Update, Prov Loc, Comments, VALTC Sum, Return, Sub Menu, Main Menu

5. Review the MMIS error message.
  - a. If the error message is “Cancel Date Must Be Greater Than Begin Date”, update the Returned Member ID Cards Tracking Log by entering a “1” in the MMIS Error Future Eligibility block, enter initials and color code the Destroy Date block dark gray.
    - I. On the envelope write the date that is listed in the “Begin Date” column.
    - II. Create a stack for Future Eligibility cards until all cards have been worked
    - III. File Future Eligibility Returned ID Cards in the Future Eligibility Begin Date Follow-up folder once the cards have balanced.
  
6. Click on the Sub Menu button to return to the Enrollment menu.

## 8.5. Reissuing New ID Card

If the ID card returned is damaged in the mail and there is a new address available to re-mail, a new card needs to generate.

### Procedure:

1. From the Enrollment Menu select the Enrollment Type "Member" and Function "ID Card Request" options, type "D" in the Reissue Reason field enter the Member ID then hit or click on the Enter button.

(Screen RS-S-001)

Screen ID: RS-S-001  
Trans ID: VE01  
Program ID: RST005VA

**VIRGINIA MEDICAID ENROLLMENT MENU**

Date: 11/15/2010  
Time: 15:43

Select Enrollment Type:  Case  
 Member  
 Case and Member  
(ADD FUNCTION ONLY)

Select Function:  Add  
 Update  
 Inquiry  
 Cancel  
 Retro Cancel Reinstate  
 Void  
 CID Request  
 Re-set ID Card  
 ID Card Request  
 Plan First Override

Re-issue Reason:

Case ID:   
Member ID:   
SSN:   
VACIS/ADAPT ID:   
Last Name:   
First Name:   
Middle Initial:   
DOB:   
Gender:   
Telephone Number:   
HIPP:

Suffix:   
New TDO Enrollee?  Yes  No

**ENTER SELECTION AND FUNCTION.**

Enter Clear Form Member Eligibility TDO Financial Case TPL Sum ID X-Ref Override Sub Menu Main Menu  
Dup Mem

2. Verify that the Member ID name is correct on the Member Demographics – ID Request Screen.

(Screen RS-S-018)

Screen ID: RS-S-018  
 Trans ID: VED8  
 Program ID: RST010VA

**VIRGINIA MEDICAID**  
 MEMBER DEMOGRAPHICS - ID REQ

Date: 10/15/2014  
 Time: 10:56

Member ID: [REDACTED] Last Name: [REDACTED] First Name: [REDACTED] MI: [REDACTED] Suffix: [REDACTED]  
 Case ID: [REDACTED] ADAPT ID: [REDACTED] VacMS ID: [REDACTED] Caseworker: [REDACTED] Case FIPS: 013 HIPP: [REDACTED] HIPP Status: [REDACTED] TPL: Y  
 Aid Category: 023 Benefit Plan: MED PREMIUM More BP: N Exception Indicator: [REDACTED] Absent Parent: N

CMM Restriction Period: [REDACTED] CMM Restriction Status: [REDACTED]

Relationship to Case Head: 00 Gender: F DOB: [REDACTED] SSN: [REDACTED] Marital Status: W Primary Language: 1  
 Cit Status: N Cit Level: GF Identity: or Cit / ID Date: 05 2013 SSA Cit Ind: Country: PM Entry Date: [REDACTED]  
 Same as Case Address: N Same as Case FIPS: Y Disability Code: [REDACTED] Disability Onset Date: [REDACTED] Mem FIPS: 013 EDD: [REDACTED] Mother ID: [REDACTED] Vet/Dep Ind: [REDACTED] NRF: [REDACTED] DOD: [REDACTED]  
 Phone: [REDACTED] Race: 1 Ethnicity: [REDACTED] Special Ind: [REDACTED]  
 Incr Type: [REDACTED] Incr Begin Date: [REDACTED] Incr End Date: [REDACTED] Incr Status: [REDACTED]

Member Address: [REDACTED]  
 City: ARLINGTON State: VA Zip Code: 22204

Card Date	Reissue Reason	Sequence #	Request #
10/01/2014	I	02	0
07/01/2013	I	01	0

View Member FIPS  View Previous Names  View Previous Address  View Aliases  View Health Conditions

Pend Claims: [REDACTED] Begin Date: [REDACTED] End Date: [REDACTED] Pend Source: [REDACTED]

**CHOOSE ID/CID TO CONFIRM REQUEST.**

Enter Update MC Assign Eligibility TDO Financial Comments Case TPL Sum ID X-Ref Sub Menu Main Menu ID/CID Dup Mem  
 BENDEX MICC Absent Parent VALTC Sum Cost Eval Case Sum Incarceration

3. From the Member Demographics – ID Request screen, click on the ID/CID button to complete the ID card request transaction.
  - a. If the transaction updated successfully, go to step 4
  - b. If the transaction update is not successful as result of exceeding amount for reissue, print screen with error message and highlight the error message on the printed copy. Paper clip the printed copy to the envelope with the returned member ID card inside and add to the stack of cards with an attachment or instructions until all cards have been worked.
  - c. Update the Returned Member ID Card Tracking Log by color coding the Member ID Number block (Column A) dark gray and placing a “1” in the Card with Attach or Instruction block, enter initials and color code the Destroy Date block dark gray
  - d. After all cards received are screened and logged, the Member ID Cards with an attachment or instructions are forwarded through interoffice delivery to the DMAS Health Care Services Customer Service Department
  - e. Click on the Sub Menu button to return to the Enrollment menu
4. Update the Returned Member ID Card Tracking Log by placing a “1” in the Re-Issued block and enter initials. The Destroy Date block remains blank pending balancing
5. Create a stack for Re-Issued ID cards until all cards have been worked
6. Click on the Sub Menu button to return to the Enrollment menu

## 8.6. Future Eligibility Begin Date

A Member MMIS record can be established in excess of 60 days in advance of the eligibility start date. The MMIS record updates occur on the 15th of the month. Document Control monitors the Member MMIS record after the 15th of the month for two consecutive MMIS cycle periods to review for an updated address. Returned Member ID cards with future eligibility begin date are reviewed on the 16th of the month.

### Procedure:

1. Retrieve returned member ID cards from the designated file.
2. Count and sort cards according to the date (begin date) that was written on the envelope. Only cards with the next month's date are worked and all others with a later months date stay in the file folder.
3. Update the Returned Member ID Cards Tracking log by typing FUT ELIG Cards in the Member ID Number block (column A) and color coding it dark gray. All other columns are coded according to procedure depending on the outcome of the card being worked.
4. Go to "Researching for New Address" procedure in Section 8.3, step 1 and begin process.

## 8.7. Balancing and Shredding Returned Cards

Each business day, Member ID cards where eligibility was cancelled and/or new ID cards were reissued are documented on the "Returned Member ID Card Log". On the following business day the Document Control Unit prints the Enrollees Cancelled and ID Card Reissues report (RS-O-120) and compares the results with the number of cards reissued and cancelled to the processing logs and/or cards to verify transactions are accurate

### Procedure:

1. Retrieve the ID cards from the balancing inbox and open the "Returned Member Log" from the Z: drive
2. To access the ID Card balancing report, follow these steps:
  - a. Go to the VAMMIS web portal and log in
  - b. Select ECM at the next screen
  - c. Select VAPRODOS1
  - d. Click "All Searches"
  - e. Click "Reports Search"
  - f. Enter RS-O-120 in the search field and hit Enter.
  - g. Double click on the triangle next to "As of Date"
  - h. Double click on the date for the report you wish to run
  - i. Click "yes" when it asks if you want to view the report
  - j. Select the [REDACTED] ID's and print only those pages

3. Verify that the number of ID cards reissued equals the total number of cards listed on the Reissued Returned ID Cards log by checking off cards against the report.
4. Verify that the number of ID cards cancelled equals the total number of cards listed on the Cancelled ID Cards log.
5. If the ID Card log and report totals are the same, check off cancelled cards against the report to verify and then place cards into the shred receptacle. Reports are kept for 30 days.

# 9. Document Retention and Destruction Procedures

Documents are filed into storage boxes and the document number range is documented on front of the storage box after imaged. The storage boxes are then staged in the onsite retention area and available for retrieval if needed. Paper documents are stored in retention for specified periods and then destroyed.

## 9.1. Paper Document Storage

Provider Enrollment, Claims and Other documents are separated during scanning. Retention boxes are stored on shelves by Julian date and document control number.

## 9.2. Paper Document Retention

Original Paper documents that are imaged are retained for the following timeframes:

1. Paper Provider Enrollment Documents - Retained for 21 days.
2. Paper Claim Documents – Retained 21 days.
3. Other Paper Documents – Retained 21 days.

At the end of the retention period documents are securely destroyed.

## 9.3. Paper Document Destruction

Documents are staged at the designated location for destruction at the end of the retention periods. The document destruction vendor retrieves and destroys documents on-site.

## 9.4. Manual Paper Tracking Logs Retention

Paper Incoming Certified Mail Tracking logs, Returned Member ID Cards Tracking logs, Incoming/Returned Checks Tracking logs, Returned Mail Tracking logs and Returned to Provider/DMAS Tracking logs are retained for 90 days.

## 9.5. Manual Paper Tracking Logs Destruction

Paper logs are removed from binders after 90 days, scanned and image stored on the [REDACTED] Shared Drive. After verification that logs are stored on the [REDACTED] Shared Drive then paper logs are destroyed.

# 10. Appendices

## 10.1. Suspicious Mail Poster

# FBI Advisory

**If you receive a suspicious letter or package**

**What should you do?**

- 1** Handle with care  
Don't shake or bump
- 2** Isolate and look for indicators
- 3** Don't Open, Smell or Taste
- 4** Treat it as Suspect!  
Call 911



### If parcel is open and/or a threat is identified...

**For a Bomb**

Evacuate Immediately  
Call 911 (Police)  
Contact local FBI

**For Radiological**

Limit Exposure - Don't Handle  
Distance (Evacuate area)  
Shield yourself from object  
Call 911 (Police)  
Contact local FBI

**For Biological or Chemical**

Isolate - Don't Handle  
Call 911 (Police)  
Wash your hands with soap and warm water  
Contact local FBI



Police Department \_\_\_\_\_

Fire Department \_\_\_\_\_

Local FBI Office \_\_\_\_\_

(Ask for the Duty Agent, Special Agent Bomb Technician, or Weapons of Mass Destruction Coordinator)

GENERAL INFORMATION BULLETIN 2000-3  
Produced by: Bomb Data Center  
Weapons of Mass Destruction Operations Unit

10.2. Outgoing Interoffice Delivery Cover  
Pages (DMAS)

**COURIER PICKUP**

**OUTGOING  
INTEROFFICE  
DELIVERY**

**DMAS MAILROOM**

**600 EAST BROAD ST**

10.3. Interoffice Delivery Cover Page (Executive Offices)

**COURIER PICKUP**

**OUTGOING  
INTEROFFICE  
DELIVERY**

**[REDACTED] EXECUTIVE  
OFFICE**

# 10.4. Check Log Sample

VA MMIS FAS and PES  
 Claims Service Operations  
 Check Log

	Receipt Date	Check Number	Check Amount	Provider/Organization Name	Initials
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					

## 10.5. Return to Provider Letter Sample (Claims)



Commonwealth of Virginia  
Department of Medical Assistance Services

Dear Provider:

The attached claim(s) is/are being returned for the following reason(s):

- \_\_\_ MISSING OR INVALID RENDERING AND/OR BILLING PROVIDER NUMBER(S)
- \_\_\_ MISSING, INVALID PROVIDER QUALIFIER OR QUALIFIER USED IN WRONG LOCATOR(S)  
(Review blocks 17a, 17b, 24I, 24J, 33a or 33b. See billing instructions)
- \_\_\_ ATTACHMENT(S) MUST BE 8 ½ x 11 inches
- \_\_\_ DAMAGED IN PROCESSING. PLEASE RESUBMIT
- \_\_\_ TITLE 18: ADJUSTMENT/VOID –CHECK THE APPROPRIATE BLOCK
- \_\_\_ DO NOT ENTER LEGACY PROVIDER NUMBER IF BILLING WITH NPL. LEAVE LOCATORS 17a, 24I, 24J and 33b SHADED AREAS BLANK. DO NOT ENTER QUALIFIER(S).
- \_\_\_ QUALIFIER ENTERED WITH NO PROVIDER NUMBER.
- \_\_\_ ENTER THE LEGACY PROVIDER NUMBER IN THE SHADED AREA IN BLOCK 24J WITH THE QUALIFIER ID IN 24I. ADD QUALIFIER AND LEGACY PROVIDER NUMBER IN 33b.
- \_\_\_ AUTHORIZED SIGNATURE/DATE MISSING
- \_\_\_ BILLING INFORMATION NOT CONFINED TO AVAILABLE SPACE/DATA NOT ALIGNED
- \_\_\_ TOO MANY CLAIM LINES/ TOO MANY PAGES/MISSING PAGES
- \_\_\_ ILLEGIBLE OR MISSING CHARGE
- \_\_\_ INVALID PRIMARY CARRIER AMOUNT
- \_\_\_ INSUFFICIENT INFORMATION FOR PROCESSING (Each block must be Completed properly. See billing instructions)
- \_\_\_ CLAIM SUBMITTED ON AN OBSOLETE FORM OR FORM VERSION IS NOT ACCEPTED AT THIS TIME
- \_\_\_ NOT A VALID VA MEDICAID CLAIM FORM
- \_\_\_ SUBMIT TO DMAS CONTRACTOR (DENTAL, PA, etc)
- \_\_\_ DOCUMENTATION NOT RECEIVED TIMELY.  
PAYMENT REDUCED (Please resubmit as an adjustment with documentation)
- \_\_\_ INVALID REVENUE CODE (4 digit code 0XXX)
- \_\_\_ ENTER ALL CLAIM INFORMATION IN BLACK INK ONLY
- \_\_\_ PRINT IS TOO LIGHT or SMALL FOR IMAGING OR SCANNING (recommend Sans Serif 10)
- \_\_\_ CARBON COPIES ARE NOT SUITABLE FOR IMAGING OR SCANNING
- \_\_\_ MARGINS NOT ALIGNED PROPERLY - DOES NOT MATCH ORIGINAL CLAIM FORM  
(Downloaded forms from the DMAS website should be printed at 100%, actual size and no page scaling)
- \_\_\_ ILLEGIBLE INFORMATION
- \_\_\_ PA REQUESTS NEED TO BE SUBMITTED TO THE APPROPRIATE ORGANIZATION. SEE PROVIDER MANUALS/MEMOS
- \_\_\_ SHADED AREA FOR TPL OR NDC INFORMATION ONLY. USE QUALIFIERS 'TPL' OR 'N4'
- \_\_\_ COB (Coordination of Benefits) CODES 2, 3, 5 ARE NO LONGER VALID. SEE PROVIDER MANUAL/MEMOS FOR TPL BILLING
- \_\_\_ COMMENT(S) AND OR LABEL(S) INTERFERES WITH THE PROCESSING OF CLAIM (Please remove and resubmit)
- \_\_\_ OTHER \_\_\_\_\_

Please return the corrected claims for processing.  
Fiscal Agent, Xerox State Healthcare, LLC Rev 10/2013

Tech \_\_\_\_\_

Date (mm/dd/yy) \_\_\_\_\_



# 10.7. Batch Cover Sheet – ER Pends

## ER Pends Batch Cover sheets

DATE RECEIVED: \_\_\_\_\_ DOCUMENT COUNT: \_\_\_\_\_

PREP. ID: \_\_\_\_\_

Operator: \_\_\_\_\_

Batch Number \_\_\_\_\_ out of \_\_\_\_\_

Transfer Pends Count	Karen Thomas Unable To Transfer	Deanna Harvey 290,03,05	Alyson Desalvo 01	Total worked	Rejects



ER Pend Letters

## 10.8. Stack Header

**SHXN11045001**



VAMMIS Mailroom

DO NOT WRITE ABOVE THIS LINE

### Stack Header

Category - CMS-1500 Typed singles

Receipt Date: **02/14/2011**

Special Batch: **No**

Priority: **No**

Printed By: 20419031 (Argerita Young)

## 10.9. Batch Cover Sheet - PAPER

**BATCH COVER SHEET  
PAPER CLAIMS**

DATE RECEIVED: \_\_\_\_\_/\_\_\_\_\_/14      PREP. ID: \_\_\_\_\_

---

PROCESS TYPE:  
**LONDON SYSTEM PROCESSING**

---

DOCUMENT TYPE:

- CMS 1500**
  - Crossover
  - Red Form – **Typed**
  - Black & White or Red Form – **Handwritten**
  
- UB04**
  - Crossover
  - Multi-Page
  - Red Form – **Typed**
  - Black & White or Red Form – **Handwritten**
  
- PHARMACY**
  
- COMPOUND PHARMACY**

---

**Processing Indicators:**

- ATTACHMENTS**       **SINGLES**
- ECO**                       **TDO**
- PRIORITY BATCH**       **SPECIAL BATCH**

# 10.10. Batch Cover Sheet – DATACAP

**BATCH COVER SHEET**  
**DATACAP**  
**DOCUMENT CLASS: CLAIMS**

DATE RECEIVED: \_\_\_\_\_ DOCUMENT COUNT: \_\_\_\_\_

PREP. ID: \_\_\_\_\_ DATE: \_\_\_\_\_

---

**DOCUMENT TYPE:**

CLAIM ATTACHMENT FORM (Electronic/EFT)

DDE - Direct Data Entry Attachment Form

---

**Processing Indicators:**

- Rescan

- Mail

## 10.11. Batch Cover Sheet – EDI



### EDI Provider Services Center Authorization Batch Cover Sheet

Prep ID : \_\_\_\_\_

Julian Date/ Scanner  
Batch Number: \_\_\_\_\_ Batch Number \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

## 10.12. Batch Cover Sheet – Return Mail



### **Return Mail** Batch Cover Sheet

Prep ID \_\_\_\_\_

Batch Number: \_\_\_\_\_ RM \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

## 10.13. Batch Cover Sheet – Termination



### **Termination** Batch Cover Sheet

Prep ID \_\_\_\_\_

Julian Date/ Scanner  
Batch Number: \_\_\_\_\_ Batch Number \_\_\_\_\_ T \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

# 10.14. Batch Cover Sheet - New Enrollment Application

 **New Enrollment Applications**

Prep ID: \_\_\_\_\_

Julian Date/ Scanner  
Batch Number: \_\_\_\_\_ Batch Number \_\_\_\_\_ A \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

**Data Entry**

Key count \_\_\_\_\_ (-) Closed count: \_\_\_\_\_ (=) Total Count: \_\_\_\_\_

Initials: \_\_\_\_\_ Completed Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Completed Date: \_\_\_\_\_

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

# 10.15. Batch Cover Sheet – New Out of State Enrollment Application

 **Out-Of-State  
NEW Enrollment Applications**

Prep ID: \_\_\_\_\_

Julian Date: \_\_\_\_\_ Scanner Batch Number: \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

**PES:**

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_ Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 10.16. Batch Cover Sheet – Missing Information



### Missing Information Letters

Prep ID: \_\_\_\_\_  
Scanner  
Julian Date/ Batch Number: \_\_\_\_\_ Batch Number \_\_\_\_\_ A \_\_\_\_\_  
Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_  
Count: \_\_\_\_\_

**PES:**

For Storage Only: \_\_\_\_\_

## 10.17. Batch Cover Sheet – Maintenance



### Maintenance Batch Cover Sheet

Prep ID: \_\_\_\_\_

Julian Date/ Scanner  
Batch Number: \_\_\_\_\_ Batch Number \_\_\_\_\_ M \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

## 10.18. Batch Cover Sheet – License Renewal



## License Renewal Batch Cover Sheet

Prep ID \_\_\_\_\_

Julian Date/ Scanner  
Batch Number: \_\_\_\_\_ Batch Number \_\_\_\_\_ LR \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

# 10.19. Batch Cover Sheet – Backend Scan

**BATCH COVER SHEET**  
DOCUMENT CLASS: **PROVIDER - BACKEND**

DATE RECEIVED: \_\_\_\_/\_\_\_\_/14      DOCUMENT COUNT: \_\_\_\_\_

PREP. ID: \_\_\_\_\_      DATE: \_\_\_\_/\_\_\_\_/14

Batch Number: \_\_\_\_\_

---

**DOCUMENT TYPE:**

ENROLLMENT APPLICATION

MAINTENANCE

MAINTENANCE – PAH/SID CHANGE

**Site Visit**

---

**Processing Indicators:**

BACKEND:	YES	<input checked="" type="checkbox"/>	NO	<input type="checkbox"/>
FAX:	YES	<input type="checkbox"/>	NO	<input checked="" type="checkbox"/>
MAIL:	YES	<input type="checkbox"/>	NO	<input checked="" type="checkbox"/>

## 10.20. Provider Enrollment Application Fee Replacement Form

### **Provider Enrollment Application Fee:**

Method of Payment if Application Fee Being Paid

Paying by Check       Paying by Credit Card

# 10.21. Batch Cover Sheet - Duplicate 1099



## **Duplicate 1099** Batch Cover Sheet

**Prep ID: 20219027**

Julian Date: \_\_\_\_\_ Scanner Batch Number: \_\_\_\_\_

Date Received: \_\_\_/\_\_\_/15 Date Worked: \_\_\_/\_\_\_/15

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

Referred \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

# 10.22. Batch Cover Sheet - PPC



## **PPC Attestation Forms** Batch Cover Sheet

Prep ID: \_\_\_\_\_

Julian Date/ Scanner  
Batch Number: \_\_\_\_\_ Batch Number: \_\_\_\_\_ P \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Worked: \_\_\_\_\_

Count: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Complete Date: \_\_\_\_\_

Approved \_\_\_\_\_

Rejected \_\_\_\_\_

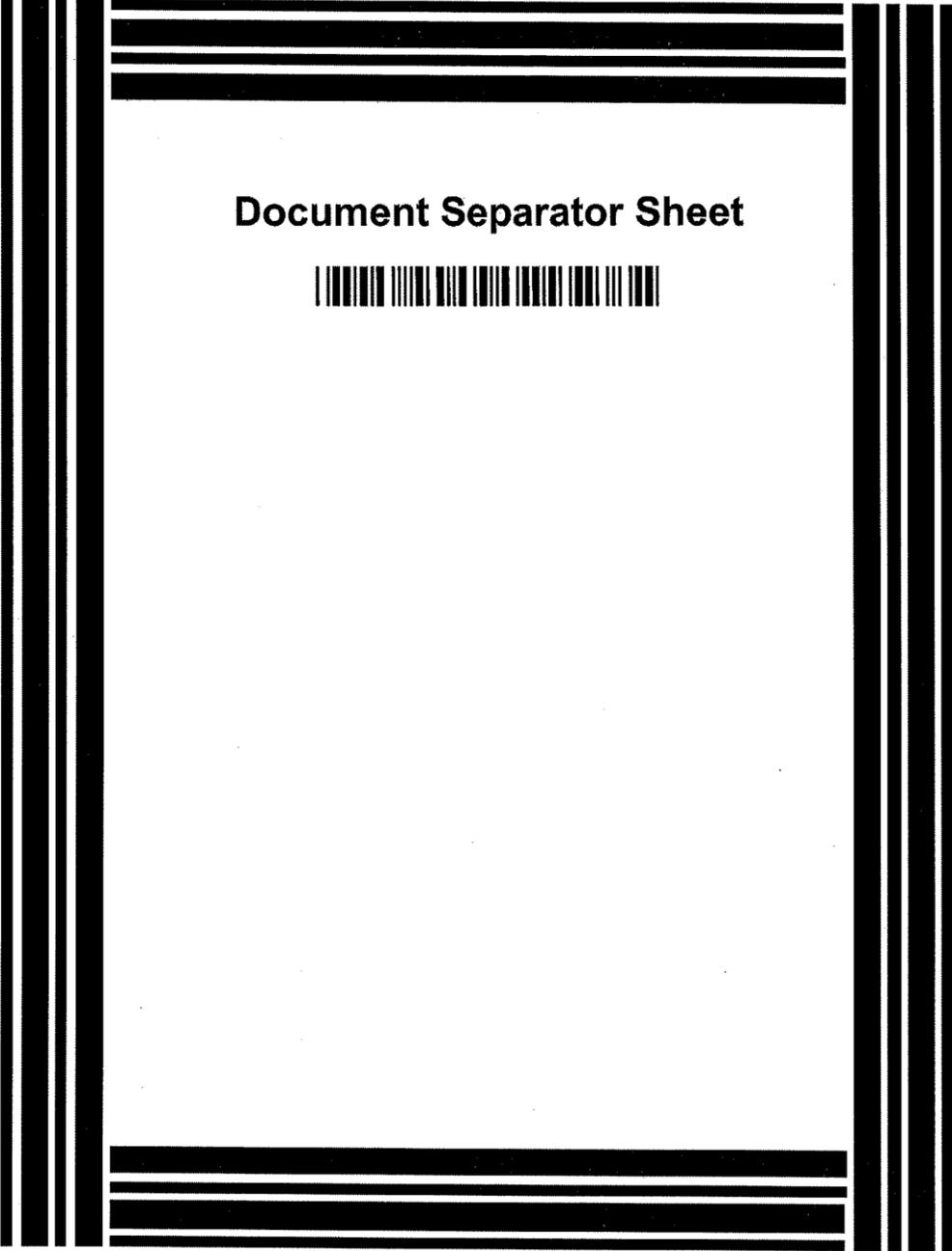
Referred \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

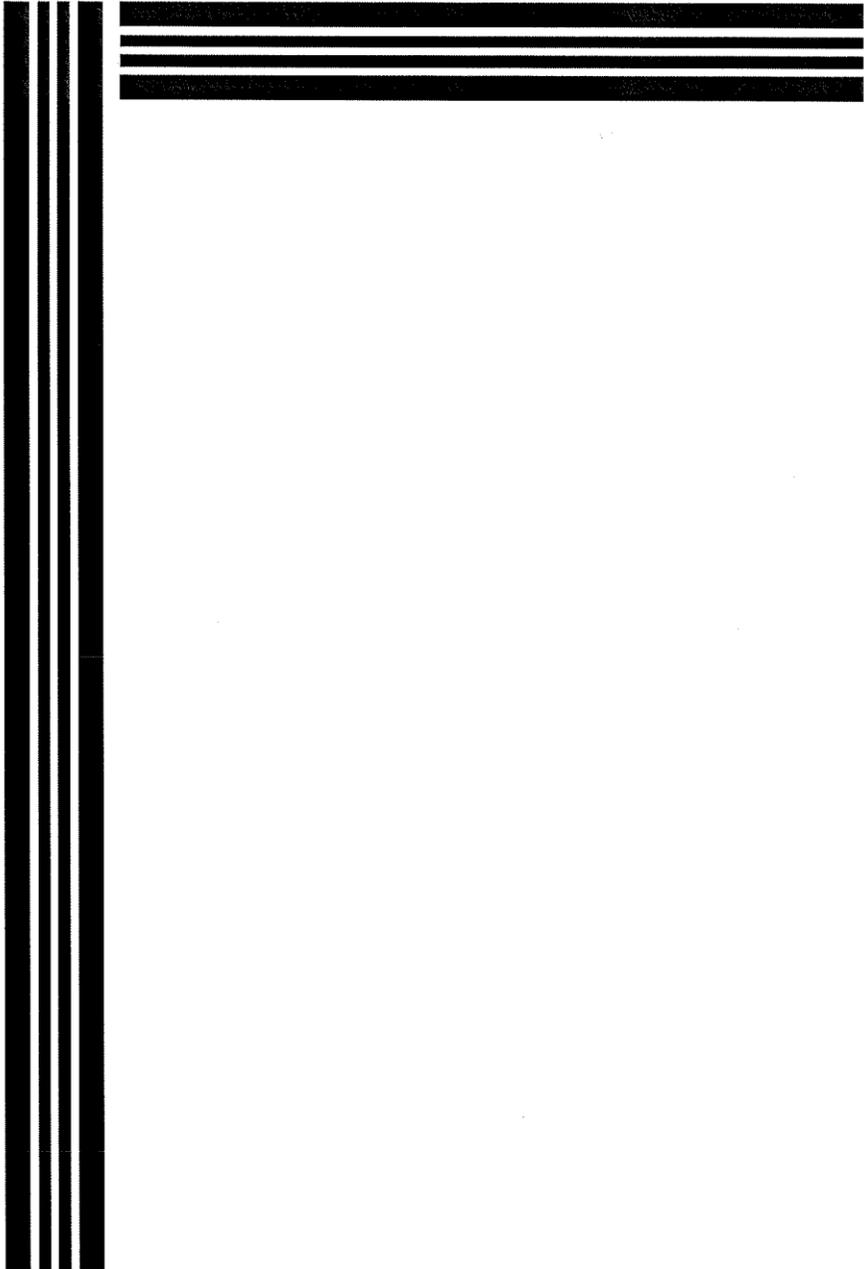
FAX: \_\_\_\_\_

MAIL: \_\_\_\_\_

# 10.23. Document Separator Sheet



10.24. [REDACTED] Document Separator



# 10.25. CMS1500 Form Sample



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
8. RESERVED FOR NUCC USE		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED _____ DATE _____		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____		b. OTHER CLAIM ID (Designated by NUCC)	
15. OTHER DATE MM DD YY QUAL _____		c. INSURANCE PLAN NAME OR PROGRAM NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, complete items 9, 9a and 9d.</i>	
17a. _____ 17b. NPI _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		SIGNED _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
A. _____ B. _____ C. _____ D. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
E. _____ F. _____ G. _____ H. _____		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO. _____	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER _____	
F. \$ CHARGES G. DAYS OR UNITS H. EPSSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. Rsvd for NUCC use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH. # ( )	
a. NPI _____ b. _____		a. NPI _____ b. _____	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12



## 10.27. Pharmacy Form Sample



# 10.28. Compound Pharmacy Form Sample

Virginia Department of Medical Assistance Services  
**COMPOUND PRESCRIPTION  
 PHARMACY CLAIM FORM**



01 Submission Code		02 Original Reference Number					
03	04	05		06	07	08	
Provider's Medical ID Number		Level of Service	Diagnosis	PAMC	Prior Authorization Number		
09		10	11	12	13		
PATIENT INFO: Medical ID Number		Last Name	First Name	Sex	Patient's Date of Birth		
14	15	16	17	18	19		
Prescriber's Medical ID Number		Prescription Number	Date Dispensed	Days Supply	Refill	Point Location	

1	20 NEC Number	21 DAW	22 Description/Drug Name	23 Marks	24 Dose/Quantity
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

25 Other Coverage Code	26 Amount Paid by Pharmacy Center	27 Amount Billed (includes dispensing fee)
------------------------	-----------------------------------	--

28 Comments: \_\_\_\_\_

---

**Provider Name, Address and Telephone Number**

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative & Date

Date

28				2	0		
----	--	--	--	---	---	--	--

DMAS-174 R 6/03



# 10.30. Dental 1999 Form Sample

## Dental Claim Form

©American Dental Association, 1999 version 2000

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		Specialty (see backside)		3. Carrier Name		
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT		Prior Authorization #		4. Carrier Address		
				5. City		6. State
						7. Zip

8. Patient Name (Last, First, Middle)		9. Address			10. City		11. State
12. Date of Birth (MM/DD/YYYY)		13. Patient ID #		14. Sex <input type="checkbox"/> M <input type="checkbox"/> F		15. Phone Number ( )	
17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		18. Employer/School Name _____ Address _____					

19. Subs./Emp. ID#/SSN#		20. Employer Name		21. Group #		31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical		32. Policy #	
22. Subscriber/Employee Name (Last, First, Middle)						33. Other Subscriber's Name			
23. Address				24. Phone Number ( )		34. Date of Birth (MM/DD/YYYY)		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
25. City		26. State		27. Zip Code		36. Plan/Program Name			
28. Date of Birth (MM/DD/YYYY)						29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		30. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.						40. Employer/School Name _____ Address _____			
X Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____						41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X Signed (Employee/subscriber) _____ Date (MM/DD/YYYY) _____			

42. Name of Billing Dentist or Dental Entity			43. Phone Number ( )		44. Provider ID #		45. Dentist Soc. Sec. or T.I.N.		
46. Address				47. Dentist License #		48. First visit date of current series:		49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other	
50. City		51. State		52. Zip Code		53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____	
55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: _____ Date of prior placement: _____						56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____			
57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____									

58. Diagnosis Code Index (optional)																										
1. _____		2. _____		3. _____		4. _____		5. _____																		
6. _____		7. _____		8. _____																						
59. Examination and treatment plans - List teeth in order																										
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only																		
60. Identify all missing teeth with "X"																										
Permanent					Primary					Total Fee																
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	Payment by other plan
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable
61. Remarks for unusual services										Deductible																
										Carrier %																
										Carrier pays																
										Patient pays																

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.				63. Address where treatment was performed			
X Signed (Treating Dentist) _____ License # _____ Date (MM/DD/YYYY) _____				64. City		65. State	
						66. Zip Code	

©American Dental Association, 1999  
J58 (Same as ADA Dental Claim Form - 4589, 4590, 4591)  
Reproduced and Distributed under ADA License 2002206

D417ADA00

# 10.31. Dental 2002 Form Sample

**ADA Dental Claim Form**

HEADER INFORMATION		PRIMARY SUBSCRIBER INFORMATION								
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – OR – <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX		12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
2. Predetermination/Preauthorization Number		13. Date of Birth (MM/DD/CCYY)								
<b>PRIMARY PAYER INFORMATION</b>		14. Gender <input type="checkbox"/> M <input type="checkbox"/> F								
3. Name, Address, City, State, Zip Code		15. Subscriber Identifier (SSN or ID#)								
<b>OTHER COVERAGE</b>		16. Plan/Group Number								
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		17. Employer Name								
5. Subscriber Name (Last, First, Middle Initial, Suffix)		<b>PATIENT INFORMATION</b>								
6. Date of Birth (MM/DD/CCYY)		18. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other								
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS								
8. Subscriber Identifier (SSN or ID#)		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number		21. Date of Birth (MM/DD/CCYY)								
10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F								
11. Other Carrier Name, Address, City, State, Zip Code		23. Patient ID/Account # (Assigned by Dentist)								
RECORD OF SERVICES PROVIDED										
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description				31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
MISSING TEETH INFORMATION										32. Other Fee(s)
34. (Place an 'X' on each missing tooth)										33. Total Fee
35. Remarks										
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION					
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.					38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other					
X _____ Patient/Guardian signature Date					39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)					
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					
X _____ Subscriber signature Date					41. Date Appliance Placed (MM/DD/CCYY)					
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)					42. Months of Treatment Remaining					
48. Name, Address, City, State, Zip Code					43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					
49. Provider ID					44. Date Prior Placement (MM/DD/CCYY)					
50. License Number					45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident					
51. SSN or TIN					46. Date of Accident (MM/DD/CCYY)					
52. Phone Number ( ) - -					47. Auto Accident State					
					<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>					
					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.					
					X _____ Signed (Treating Dentist) Date					
					54. Provider ID					
					55. License Number					
					56. Address, City, State, Zip Code					
					57. Phone Number ( ) - -					
					58. Treating Provider Specialty					

©American Dental Association, 2002  
 J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746  
 or go online at www.adacatalog.org

# 10.32. Assessment Form Sample

## MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

### I. RECIPIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
 Social Security \_\_\_\_\_ Medicaid ID \_\_\_\_\_ Sex: \_\_\_\_\_

### II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?   
 1 = Yes  
 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission OR within 45 days of application or when personal care begins.  
 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission  
 If no, has Individual formally applied for Medicaid?   
 0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?   
 0 = No  
 1 = Yes, or has applied for Auxiliary Grant  
 2 = No, but is eligible for General Relief  
 Dept of Social Services:  
 (Eligibility Responsibility) \_\_\_\_\_  
 (Services Responsibility) \_\_\_\_\_

### III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

#### MEDICAID AUTHORIZATION

Level of Care   
 1 = Nursing Facility (NF) Services  
 2 = PACE  
 3 = AIDS/HIV Waiver Services  
 4 = Elderly or Disabled w/Consumer Direction (EDCD) Waiver  
 11 = ALF Residential Living  
 12 = ALF Regular Assisted Living  
 14 = Individual/Family Developmental Disabilities Waiver  
 15 = Technology Assisted Waiver  
 16 = Alzheimer's Assisted Living Waiver

Exceptions: Authorizations for NF, PACE, AIDS or the EDCD Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF, NF = EDCD, AIDS, or PACE Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF, however, the individual must also have a diagnosis of Alzheimer's or Alzheimer's Related Dementia and meet the NF criteria. NF = Alzheimer's ALF

#### NO MEDICAID SERVICES AUTHORIZED

8 = Other Services Recommended  
 9 = Active Treatment for MI/MR Condition  
 0 = No other services recommended

#### Targeted Case Management for ALF

0 = No 1 = Yes   
**ALF Reassessment Completed**  
 1 = Full Reassessment 2 = Short Reassessment

ALF provider name: \_\_\_\_\_  
 ALF provider number: \_\_\_\_\_  
 ALF admit date: \_\_\_\_\_

#### SERVICE AVAILABILITY

1 = Client on waiting list for service authorized   
 2 = Desired service provider not available  
 3 = Service provider available, care to start immediately

#### LENGTH OF STAY (If approved for Nursing Home)

1 = Temporary (less than 3 months)   
 2 = Temporary (less than 6 months)  
 3 = Continuing (more than 6 months)  
 8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility, PACE, HIV/AIDS waiver and the EDCD Waiver. The progress notes should be provided to the local departments of social services Eligibility workers.

#### LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:  
 1. \_\_\_\_\_

2. \_\_\_\_\_

#### LEVEL II ASSESSMENT DETERMINATION - FOR NF AUTHS ONLY - DOES NOT APPLY TO WAIVERS.

Name of Level II Screener and ID number who have completed the Level II for a diagnosis of MI, MR/ID, or RC.

1. \_\_\_\_\_

0 = Not referred for Level II assessment  
 1 = Referred, Active Treatment needed   
 2 = Referred, Active Treatment not needed  
 3 = Referred, Active Treatment needed but individual chooses NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No

**SCREENING CERTIFICATION** - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____	_____	___/___/___
Level I/ALF Screener	Title	Date
_____	_____	___/___/___
Level I/ALF Screener	Title	Date
_____	_____	___/___/___
Level I Physician		Date

DMAS-96 (revised 02/09)

# VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Date: Screen \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Assessment \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Reassessment \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 1 IDENTIFICATION/BACKGROUND

### Name & Vital Information

Client Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) Client SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)  
 Phone: (\_\_\_\_) \_\_\_\_\_ City/County Code: \_\_\_\_\_  
 Directions to Home \_\_\_\_\_ Pets? \_\_\_\_\_

### Demographics

Birthdate: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Month) (Day) (Year) Age: \_\_\_\_\_ Sex:  Male  Female  
 Marital Status:  Married  Widowed  Separated  Divorced  Single  Unknown  

Race:	Education:	Communication of Needs:
<input type="checkbox"/> White	<input type="checkbox"/> Less than High School	<input type="checkbox"/> Verbally, English
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Some High School	<input type="checkbox"/> Verbally, Other Language
<input type="checkbox"/> American Indian	<input type="checkbox"/> High School Graduate	Specify _____
<input type="checkbox"/> Oriental/Asian	<input type="checkbox"/> Some College	<input type="checkbox"/> Sign Language/Gestures/Deaf
<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> College Graduate	<input type="checkbox"/> Does Not Communicate
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	Hearing Impaired? _____

 Ethnic Origin \_\_\_\_\_ Specify \_\_\_\_\_

### Primary Caregiver/Emergency Contact/Primary Physician

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_)  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_)  
 Name of Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

### Initial Contact

Who called: \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship to Client) \_\_\_\_\_ (Phone)  
 Presenting Problem/Diagnosis: \_\_\_\_\_

**MEDICAID HIV WAIVER SERVICES PRE-SCREENING PLAN OF CARE**

Name: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

**I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider**

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living	_____	_____	_____	_____
Housekeeping	_____	_____	_____	_____
Living Space	_____	_____	_____	_____
Meals/Nutritional Supp	_____	_____	_____	_____
Shopping/Laundry	_____	_____	_____	_____
Transportation	_____	_____	_____	_____
Supervision	_____	_____	_____	_____
Medicine Administration	_____	_____	_____	_____
Financial	_____	_____	_____	_____
Legal Services	_____	_____	_____	_____
Child Care	_____	_____	_____	_____
Foster Care	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Counseling/Therapy	_____	_____	_____	_____
Substance Abuse Treatment	_____	_____	_____	_____
Health Education	_____	_____	_____	_____
Support Groups	_____	_____	_____	_____
Buddies/Companions	_____	_____	_____	_____
Home Health	_____	_____	_____	_____
Rehabilitation	_____	_____	_____	_____
Outpatient Clinic	_____	_____	_____	_____
Equipment/Supplies	_____	_____	_____	_____
Physician	_____	_____	_____	_____
Hospice	_____	_____	_____	_____
Laboratory Services	_____	_____	_____	_____
Other	_____	_____	_____	_____

**II. MEDICAID HIV WAIVER SERVICES: The following services are authorized to prevent institutionalization**

**CASE MANAGEMENT:** \_\_\_\_\_ Provider: \_\_\_\_\_ Date Referred: \_\_\_\_\_

**NUTRITIONAL SUPPLEMENTS:** \_\_\_\_\_ Physician's Order Attached \_\_\_\_\_ Authorization Form to Recipient \_\_\_\_\_

**PERSONAL CARE:** \_\_\_\_\_ Provider: \_\_\_\_\_ Date Referred: \_\_\_\_\_

**PRIVATE DUTY NURSING** \_\_\_\_\_ Provider \_\_\_\_\_ Date Referred \_\_\_\_\_

**RESPIRE CARE:** \_\_\_\_\_ Reason Requested: \_\_\_\_\_  
 Provider: \_\_\_\_\_ Type of Respite: Aide \_\_\_\_\_ LPN \_\_\_\_\_ RN \_\_\_\_\_ Date Requested \_\_\_\_\_

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient \_\_\_\_\_ Date \_\_\_\_\_ PAS Staff \_\_\_\_\_ Date \_\_\_\_\_

JN5AS 113-N (rev 9/93)

**PROVIDER COPY**

# 10.33. TAD Letter Sample



**COMMONWEALTH of VIRGINIA**  
Department of Medical Assistance Services  
**TIME SENSITIVE MATERIAL**

VAMMIS\_LtrPull#060512\_Rual.Ext - 1 0 - 0 AS011 1 of 2

MONTGOMERY SOCIAL SERVICES

210 PEPPER ST S STE B  
CHRISTIANSBURG VA 24073-3572

|||||

JUNE 4, 2012

ACN # 2012153115052

Enrollee Name: [REDACTED]  
Enrollee ID #: [REDACTED]  
Assessment Date: 05/16/2012  
Medicaid Auth: 11

Recently, a screening assessment form was submitted for processing. However, after careful review of the form, it has been determined that certain data elements were either missing, inappropriate, or incomplete.

Please make the necessary corrections to the items listed on the attached turn-around document and return the entire package, along with this letter, to the address listed below within five (5) working days of the receipt of this letter. The following items that require corrections are marked with double asterisks (\*\*) on the attached turn-around document.

Virginia Medicaid  
Post Office Box 85083  
Richmond, Virginia 23285-5083

SPECIAL NOTE: Any questions regarding the submission of this information or any other related issue must be directed to the Facility and Home-Based Services Unit at (804)225-4222.

JUN 0 8 2012

## 000155021427016 0000000000000000 06042012 0001 P 1 00 0 00 000 0000000000000001 AS011



# 10.34. ER Pend Letter Sample



**COMMONWEALTH of VIRGINIA**  
Department of Medical Assistance Services  
**TIME SENSITIVE MATERIAL**

VAMNIS\_LtrE1\_062812\_Run1\_1 - 43 2 - 42 CPO44406 1 of 1

JOHN RANDOLPH MEDICAL CENTER

7300 BEAUFONT SPRINGS DR BLDG VIII  
NORTH CHESTERFIELD VA 23225-5551

|||||

[Redacted]  
ID: [Redacted]

|||||

Patient: [Redacted]  
Patient Account Number: [Redacted]  
Enrollee ID Number: [Redacted]  
ICN Number: [Redacted]  
Service Date: 03/26/2012

Dear Provider:

Your claim has pended for review because you are billing for services rendered in an emergency room to an enrollee in the Medicaid Program. In order for the Virginia Medical Assistance Program to consider your claim for payment, please submit a copy of the emergency room record for the service date listed above.

No further action will be taken within the next twenty-one (21) days pending receipt of the required documentation. If, by that time, the documentation is not received, the claim will be paid at a reduced rate.

To ensure proper handling, please attach this letter to the document and return to: Virginia Medicaid, P.O. Box 26228, Richmond, VA 23260.

Sincerely,

Fiscal Agent

Purge Date: 07/17/2012  
CP-O-444-06  
CPR291

**MEDICAL  
RECORDS  
ATTACHED**



### 000001285471248 000550083874031 00282012 0001 P I 00 0 00 000 0000000000000043 CPO44406

# 10.35. Electronic Attachment Form Sample

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES  
CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

\*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:
------------------	----------------

Enrollee Identification Number:
---------------------------------

Enrollee Last Name:	First Name:	MI:
---------------------	-------------	-----

<input type="checkbox"/> Paper Attached	<input type="checkbox"/> Photo(s) Attached	<input type="checkbox"/> X-Ray(s) Attached
<input type="checkbox"/> Other (specify) _____		

COMMENTS: _____ _____ _____ _____ _____
---

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS
--

Authorized Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Mailing addresses are available in the Provider manuals or check DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov). Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3 R. 6/03

# 10.36. Direct Data Entry Attachment Claim Submittal Form Sample

Claims Submitted - 09/28/13 - 1:00

Your Professional claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

**Claim Information**

ICN Number: [REDACTED]      ACM: [REDACTED]

Date of Service: [REDACTED]

Provider #: [REDACTED]

Provider Name: [REDACTED]

Member ID: [REDACTED]

Member Name: [REDACTED]

Total Charge: [REDACTED]

Submission Date/Time: [REDACTED]

**Mailing Address**

Please send additional documentation to the following address:

**Department of Medical Assistance Services**  
P.O. Box 27822  
Richmond, Virginia 23261-7444

[Print Submission Page](#)      [Submit Another Claim](#)      [Claims Menu](#)

Claims Submitted

Your Institutional claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

**Claim Information**

ICN: [REDACTED]      ACM: [REDACTED]

Date of Service: [REDACTED]

Provider #: [REDACTED]

Provider Name: [REDACTED]

Member ID: [REDACTED]

Member Name: [REDACTED]

Total Charge: [REDACTED]

Submission Date/Time: [REDACTED]

**Mailing Address**

Please send additional documentation to the following address:

**Department of Medical Assistance Services**  
P.O. Box 27822  
Richmond, Virginia 23261-7444

[Print Submission Page](#)      [Submit Another Claim](#)      [Claims Menu](#)

# 10.37. Provider Missing Information Letters



**COMMONWEALTH of VIRGINIA**  
Department of Medical Assistance Services  
Provider Enrollment Services

VAMMIS\_PSRLEtrs\_041014\_1.txt - 20 PES-001 1 of 1

4/10/2014

NPI/API: :  
Re:

Dear Provider:

Thank you for your interest in becoming a participating provider with the Virginia Medicaid Program.

This letter is to inform you that in order to complete the processing of your application we are in need of the following information:

- Copy of License and/or Certification
- Other: See Below

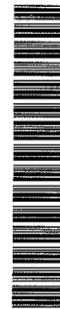
Please submit a copy of your license from DBHDS

In order for us to complete the processing of your application, we must receive this information within 30 calendar days of the date of this letter. If the information is not received within this timeline, your application will be rejected. You can submit your information as follows:

- If you submitted your application through the web portal, you may upload your attachments there. From the Provider Enrollment Status screen, find the pended application that is missing documentation. It will display a 'Pend' status. You will see an 'Upload' link displayed. Clicking on this link will allow you to attach the appropriate documentation needed to continue the processing of your application. You can submit multiple attachments but each attachment is restricted to a maximum of 3 MBs.
- If you sent a paper application or you are unable to upload your documents through the web portal, you may fax the missing documents along with a copy of this letter to Provider Enrollment Services at 1-888-335-8476. Please make sure a copy of this letter is enclosed to ensure your documents are matched with your pended application.

If the required information is not received within 30 days of the date of this letter, your application will be rejected and you will need to complete the application process from the beginning.

(Continued on Back)



If you have any questions, please call Provider Enrollment Services at 888-829-5373 or 804-270-5105 (local) or visit [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov).

Thank you,

Provider Enrollment Services



**COMMONWEALTH of VIRGINIA**  
Department of Medical Assistance Services  
Provider Enrollment Services

VAMMIS\_PSRLEtrs\_032714\_1.txt - 5 PES-002 1 of 1

**2nd Request**

3/27/2014

NPI/API:  
Re:

Dear Provider:

This letter is being sent as a reminder that your application to participate in the Virginia Medicaid Program is still pending for the information identified below.

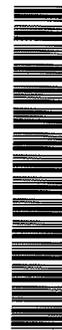
- Copy of License and/or Certification

In order for us to complete the processing of your application, we must receive this information within 15 calendar days of the date of this letter. If the information is not received within this timeline, your application will be rejected. You can submit your information as follows:

- If you submitted your application through the web portal, you may upload your attachments there. From the Provider Enrollment Status screen, find the pended application that is missing documentation. It will display a 'Pend' status. You will see an 'Upload' link displayed. Clicking on this link will allow you to attach the appropriate documentation needed to continue the processing of your application. You can submit multiple attachments but each attachment is restricted to a maximum of 3 MBs.
- If you sent a paper application or you are unable to upload your documents through the web portal, you may fax the missing documents along with a copy of this letter to Provider Enrollment Services at 1-888-335-8476. Please make sure a copy of this letter is enclosed to ensure your documents are matched with your pended application.

If the required information is not received within 15 days of the date of this letter, your application will be rejected and you will need to complete the application process from the beginning.

(Continued on Back)



If you have any questions, please call Provider Enrollment Services at 888-829-5373 or 804-270-5105 (local) or visit [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov).

Thank you,

Provider Enrollment Services

# 10.38. Provider Enrollment Package



## COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

### Physician

#### VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

Thank you for your interest in becoming a participating provider with the Virginia Medicaid program. Upon receipt of your completed Virginia Medicaid / Family Access to Medical Insurance Security Plan (FAMIS) enrollment application and any required documents, your application will be processed. Processing of your application may take up to ten business days. Completed paper enrollment applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free Fax 1-888-335-8476

Virginia Medicaid Provider Enrollment Services  
PO Box 26803  
Richmond, VA 23261-6803

If you have any questions regarding your paper enrollment application, you can contact Provider Enrollment Services toll-free at 1-888-829-5373 or local 1-804-270-5105.

#### Contents:

- Enrollment Form Instructions - Read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Make sure all required fields are complete prior to submission.
- Reassignment of Benefits (ROB) Form - Make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.

VIRGINIA MEDICAID ENROLLMENT FORM

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. **National Provider Identifier (NPI) (Required)** \_\_\_\_\_
  
2. **Individual Provider Name (Required)**  
First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_ Title \_\_\_\_\_  
*Enter the name which identifies individual provider to the public*
  
3. **Primary Servicing Address (Required)**  
If you are a member of a group practice, enter the group practice NPI for this servicing address \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone (Required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (Required) \_\_\_\_\_  
Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_
  
4. **Correspondence Address (Required)**  
Attention \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (Required) \_\_\_\_\_  
Do you want to receive mailed Medicaid correspondence at this address?  Yes or  No
  
5. **Pay To Address (Optional)**  
Attention \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_  
Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_
  
6. **Remittance Advice Address (Optional)**  
Attention \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_
  
7. **Social Security Number (SSN) and Date of Birth (Required)**  
SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_
  
8. **IRS Name and Taxpayer Identification Number (Optional for individuals who bill and accept payments through a group practice)**  
IRS Name \_\_\_\_\_  
Taxpayer Identification Number (TIN) \_\_\_\_\_

9. **Doing Business as (DBA) Name (Optional)** \_\_\_\_\_

10. **Requested Effective Date of Enrollment (Required)** \_\_\_\_\_

11. **License and Required Documents (Required)**

**State Medical Board** State \_\_\_\_\_  
License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

Attach Copy if your license cannot be validated through an Internet search.

**DPOR** State \_\_\_\_\_  
License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

Attach Copy if your license cannot be validated through an Internet search.

12. **Specific Requirements for Different Provider Types (Required)**

12.1. **Specific Requirements for Baby Care Services (Required)**

Select all services that you are applying for.

**Care Coordination (Attach Copy)**  
License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

**Homemaker Services (Attach Copy)**  
License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

**Nutritional Services (Attach Copy)**  
License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

**Patient Education Services (Attach Request for Approval and Supporting Documents)**  
License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

12.2. **Specific Requirements for Chiropractors (Required)**

Attach copy of claim(s) for services rendered or supporting documentation indicating services to be rendered

12.3. **Specific Requirements for Nurse Practitioner (Required)**

Select one specialty

- Acute Care
- Adult
- Certified Nurse Midwife
- Family
- Geriatric
- Neonatal
- Pediatric
- Psychiatric
- Women's Health (OB/GYN.)

12.4. **Specific Requirements for Psychiatrists (Required)**

Attach copy of Provider's Three Year Residence Certification of Curriculum Vitae or Three Year Residency in Psychiatry.

13. **Mammography Services (Required)**

Are you currently conducting breast cancer screening or diagnosis through mammography activities?  Yes  No

If Yes, attach a copy of the required certification issued by the FDA under the Mammography Quality Standards Act (MQSA).

**14. Medical Specialties (Primary Specialty Required)**

**14.1. Primary Specialty (Required) select one**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesiology           | <input type="checkbox"/> Infectious Disease      | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Cardiac Surgery          | <input type="checkbox"/> Internal Medicine       | <input type="checkbox"/> Plastic Surgery                    |
| <input type="checkbox"/> Cardiology               | <input type="checkbox"/> Neonatology             | <input type="checkbox"/> Preventative Medicine              |
| <input type="checkbox"/> Colon and Rectal Surgery | <input type="checkbox"/> Nephrology              | <input type="checkbox"/> Psychiatry                         |
| <input type="checkbox"/> Critical Care            | <input type="checkbox"/> Neurological Surgery    | <input type="checkbox"/> Pulmonary                          |
| <input type="checkbox"/> Dermatology              | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Radiation Oncology                 |
| <input type="checkbox"/> Doctor of Osteopathy     | <input type="checkbox"/> Nuclear Medicine        | <input type="checkbox"/> Radiology                          |
| <input type="checkbox"/> Emergency                | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Rheumatoid                         |
| <input type="checkbox"/> Endocrinology            | <input type="checkbox"/> Ophthalmology           | <input type="checkbox"/> Substance Abuse                    |
| <input type="checkbox"/> Ear, Nose, and Throat    | <input type="checkbox"/> Orthopedic Surgery      | <input type="checkbox"/> Surgery Cardiothoracic             |
| <input type="checkbox"/> Family Practice          | <input type="checkbox"/> Osteopathy              | <input type="checkbox"/> Thoracic Surgery                   |
| <input type="checkbox"/> Gastroenterology         | <input type="checkbox"/> Otolaryngology          | <input type="checkbox"/> Transplant Surgery                 |
| <input type="checkbox"/> General Practice         | <input type="checkbox"/> Pathologist             | <input type="checkbox"/> Urology                            |
| <input type="checkbox"/> General Surgery          | <input type="checkbox"/> Pediatrics              | <input type="checkbox"/> Vascular                           |
| <input type="checkbox"/> Hematology/Oncology      | <input type="checkbox"/> Perinatology            |   |

**14.2. Secondary Specialties (Optional) select all that apply**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesiology           | <input type="checkbox"/> Infectious Disease      | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Cardiac Surgery          | <input type="checkbox"/> Internal Medicine       | <input type="checkbox"/> Plastic Surgery                    |
| <input type="checkbox"/> Cardiology               | <input type="checkbox"/> Neonatology             | <input type="checkbox"/> Preventative Medicine              |
| <input type="checkbox"/> Colon and Rectal Surgery | <input type="checkbox"/> Nephrology              | <input type="checkbox"/> Psychiatry                         |
| <input type="checkbox"/> Critical Care            | <input type="checkbox"/> Neurological Surgery    | <input type="checkbox"/> Pulmonary                          |
| <input type="checkbox"/> Dermatology              | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Radiation Oncology                 |
| <input type="checkbox"/> Doctor of Osteopathy     | <input type="checkbox"/> Nuclear Medicine        | <input type="checkbox"/> Radiology                          |
| <input type="checkbox"/> Emergency                | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Rheumatoid                         |
| <input type="checkbox"/> Endocrinology            | <input type="checkbox"/> Ophthalmology           | <input type="checkbox"/> Substance Abuse                    |
| <input type="checkbox"/> Ear, Nose, and Throat    | <input type="checkbox"/> Orthopedic Surgery      | <input type="checkbox"/> Surgery Cardiothoracic             |
| <input type="checkbox"/> Family Practice          | <input type="checkbox"/> Osteopathy              | <input type="checkbox"/> Thoracic Surgery                   |
| <input type="checkbox"/> Gastroenterology         | <input type="checkbox"/> Otolaryngology          | <input type="checkbox"/> Transplant Surgery                 |
| <input type="checkbox"/> General Practice         | <input type="checkbox"/> Pathologist             | <input type="checkbox"/> Urology                            |
| <input type="checkbox"/> General Surgery          | <input type="checkbox"/> Pediatrics              | <input type="checkbox"/> Vascular                           |
| <input type="checkbox"/> Hematology/Oncology      | <input type="checkbox"/> Perinatology            |   |

**15. Languages Other Than English Spoken - Check All That Apply (Optional)**

- Farsi  Hindi  Korean  Spanish  Vietnamese  Other: \_\_\_\_\_

**16. Signature Waiver  Yes  No (Required)**

I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.

**SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104. AND 42 C.F.R. §455.106.**

**17. Ownership and Control Information for Disclosing Entity (Required)**

List any managing employee and/or any individual(s) or organization(s) that has any ownership or controlling interest in this provider entity. The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement.

List the Individual Name or Organization Name, Title (i.e. CEO, MD, Pres.), Date of Birth, SSN/Tax ID (TIN), Type of Ownership, Address and Percentage of Ownership. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		
Name/Organization				Title	
Date of Birth	SSN/TIN	Ownership Type	Percent		
Street Address	City	State	Zip		

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**18. Relationships (Required)**

List those individuals named in the previous question who are related to each other (spouse, parent, child, or sibling) and whom they are related to.

Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		
Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		
Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		
Name Listed Above		
Relationship (i.e. spouse, parent, child, or sibling)		
Is Related to (Name)		

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**19. Subcontractors (Required)**

List the Name, Title, Date of Birth, SSN/TIN, Address and Percentage of Ownership for any individual with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____
Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____
Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____
Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**20. Other Disclosing Entity (Required)**

List the name, title, Date of Birth, SSN/TIN, Percent Ownership and Address of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more.

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____
Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____
Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____
Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
	_____	State	_____
	_____	Zip	_____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**21. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)**

Has any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

No  Yes (if Yes please provide the Name, Title, Date of Birth, Address, and SSN/TIN information for individual(s) or organization(s). Attach copy of the final disposition.

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_ Title \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If more space is needed, attach additional paper listing all of the required information for the additional individual or organization.

**22. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)**

Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

No  Yes (if yes, please provide the Name, Date of Birth, Address, and SSN/TIN information for the individual(s) or contractors below. Attach a copy of the final disposition.

Name/Organization \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name/Organization \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If more space is needed attach additional paper listing all of the required information for the additional individual or organization.

**23. Adverse Legal Actions (Required)**

Indicate if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, any other Federal or State agency or program, or any licensing or certification agency.

No  Yes If Yes, attach a copy of any final disposition documentation.

**SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION (Required)**

**24. Electronic Funds Transfer (Required for Solo Practitioners. Optional for Individuals Who Bill and Accept Payments through a Group Practice)**

Yes, I will participate in EFT of payments directly deposited into my financial account. Complete the following:

Account Type  Checking  Savings  Other

Name of Financial Institution \_\_\_\_\_

Routing or ABA number \_\_\_\_\_

Account Number \_\_\_\_\_

No, I am filing for an exemption from participation in EFT for good cause.

I am attaching a letter from my financial institution stating the inability of the institution to transact business using EFT.

I am attaching a letter describing my good cause for exemption.

**25. Electronic Claims Submission (Required for Solo Practitioners. Optional for Individuals Who Practice with a Group)**

I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE) on the Virginia Medicaid Web Portal as part of my enrollment with Virginia Medicaid and FAMIS.

I am requesting an exemption from filing my claim(s) electronically at this time for the following reasons:

Unavailability of the infrastructure necessary to support electronic claims submission in my geographic region. If checked attach supporting documentation.

No mechanism for electronic submission for the particular claim types I bill Virginia Medicaid. If checked attach supporting documentation.

Financial Hardship. If checked, attach supporting documentation.

Other: \_\_\_\_\_  
To be considered for an exemption, attach supporting documentation.

**26. Electronic Remittance Advice (ERA) (Optional)**

Yes, I would like to request participation in electronic remittance advices as part of my enrollment with Virginia Medicaid and FAMIS. Complete the following:

Service Center Name \_\_\_\_\_

Service Center ID Number \_\_\_\_\_

**SECTION IV: REASSIGNMENT OF BENEFITS (ROB)**

The completion of this section is required for individuals who bill and accept payments through a group practice. Make additional copies of the ROB as necessary for enrollment into additional Group Practice NPIs under same TIN.

**27. Reassignment of Benefits (ROB) (Optional)**

Group Practice Legal Business Name \_\_\_\_\_

Group Practice Taxpayer Identification Number (TIN) \_\_\_\_\_

Group Practice National Provider Identifier (NPI) \_\_\_\_\_

Yes I certify that the authorized administrator listed for this group has validated the information above for this group that it is true, accurate, and complete to the best of the applying provider's knowledge, and that the business entity (employer, group, or health care delivery system) requesting to receive payment is legally eligible to receive reassigned benefits per all applicable federal and state laws.

Group Authorized Administrator \_\_\_\_\_

Yes I certify that this Reassignment of Benefits Statement authorizes the business entity identified in above to receive Virginia Medicaid payments on my behalf.

Individual Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**28. Remarks (Optional)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**COMMONWEALTH of VIRGINIA**

**Department of Medical Assistance Services  
Medical Assistance Program**

**Physician Participation Agreement**

**This is to certify:**

**Provider Name** \_\_\_\_\_

**NPI** \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
11. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. This agreement shall commence upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. The provider shall retain a copy of this approval letter as part of the Participation Agreement. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

<b>For Virginia Medicaid use only</b>	
Director, Division of Program Operations	Date

\_\_\_\_\_  
Original Signature of Provider      Date

**Addendum A - Additional Servicing Addresses (make additional copies as needed)**

A. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street	City	State	Zip
--------	------	-------	-----

Office Phone (required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

B. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street	City	State	Zip
--------	------	-------	-----

Office Phone (required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

C. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street	City	State	Zip
--------	------	-------	-----

Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

D. If you are a member of a group practice, enter the group practice NPI for this servicing address: \_\_\_\_\_

Attention \_\_\_\_\_

Address \_\_\_\_\_

Street	City	State	Zip
--------	------	-------	-----

Office Phone (required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_