RESIDENTIAL FACILITY CLAIM FORM

Mail Claims To:

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

Required fields denoted with an asterisk *

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

*** Member ID Number:** | **DOB:** | **Gender:**

Patient Account Number:

*** Billing Provider Name:** | *** Tax ID Number:**

*** Billing/Remit Address:** | **NPI** *(Not required for Residences):*

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

*** Rendering Facility Name:** | *** Rendering Facility Address:**

*** City, State & Zip:**

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

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

***Diagnosis Code:** (Refer to key)

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

RESIDENTIAL FACILITY CLAIM KEY

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

Field	What To Enter
Member/Client Name *	Name (first, middle initial and last) of iCare client
Member ID Number *	Member's Medicaid Number (located on the service request summary created by the Care Manager)
Patient Account Number	Provider's own internal account number for the member
DOB	Member's date of birth (mm/dd/yyyy)
Gender	Male or female
Type of Bill (choose one)*	861 - Respite services
	862 - First claim for client
	863 - Continuous claim for an ongoing stay
	864 - Last claim for client
Billing Provider Name *	Name of billing facility
Billing/Remit Address *	Address where payment should be sent
City, State & Zip *	City, state and zip code of billing provider
Tax ID Number *	Federal Tax ID number or social security number under which you bill
NPI (if applicable)	National Provider Identifier (assigned to most providers of medical services, not residences)
Service Request Number	Number on the summary created by the Care Manager which authorizes services
Rendering Facility Name*	Name of facility where services were rendered
Rendering Facility Address*	Address of facility where services were rendered
City, State & Zip*	City, state and zip code of facility where services were rendered
Statement Period From *	First date of billing period; must be in mm/dd/yyyy format.
Statement Period To *	Last date of billing period; must be in mm/dd/yyyy format.
Admission Date	Original admission date to facility or residence; must be in mm/dd/yyyy format.
Discharge Status (choose one)*	01 - Discharge to home or self-care (routine discharge)
	02 - Discharged or transferred to hospital or inpatient care
	03 - Discharged or transferred to a skilled nursing facility
	04 - Discharged or transferred to an intermediate care facility
	05 - Discharged or transferred to another type of institution for inpatient care
	07 - Left against medical advice or discontinued care
	20 - Expired/died
	30 - Still a patient (ongoing stay)
Diagnosis Code*Effective 10/1/2015	Diagnosis of member use default to Z02.9 if unknown for **Date of Service 10/1/2015**
HIPAA Service Code	Only required if included in your authorization
Revenue Code *	Revenue code provided by iCare which can be located on the letter that authorizes services. It must be
Modifier * (if applicable)	2-digit/character code that provides specific information relating to HIPAA or revenue code (if applicable); located on the service request summary under the procedure name.
Billing Period From Date *	Date services for which you are billing began; must be in mm/dd/yyyy format.
Billing Period To Date *	Date services for which you are billing ended; must be in mm/dd/yyyy format.
Number of Days/Units *	Number of units or days billed for the specific code listed on the service line; MUST
Rate per Day/Unit Amt. *	Dollar amount/rate per day or unit.
Total Billed Amount *	Billed amount for services on that line
Grand Total *	Total of all service lines
Signature*	The Provider Signature indicates responsibility for the implementation of the MCP as described in the Service Authorization