



CLAIMS

Billing Address:

Molina Healthcare of Michigan, Inc.
P.O. Box 22668
Long Beach, CA 90801

Please do not submit initial claims to the Troy address as this will delay the processing of your claims, and your claim may be returned. Please contact the Claims Department with any questions or concerns at 1-888-898-7969.

Claims Submission Guidelines

Filing Limit

- Claims should be sent to Molina Healthcare within 90 days from the date of service.
- For resubmission or secondary claims, Molina Healthcare must receive the claim within 180 days from the date of service.
- If a claim is submitted to Medicaid or another HMO in error prior to the claim being submitted to Molina Healthcare, the submission limit is not extended. Eligibility must be verified prior to rendering services.
- Molina Healthcare responds to claims within State processing guidelines. The Claims determination will be reported to the provider on a Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call the Claims Call Center at 1-888-898-7969 to status the claim(s).
- All claims received beyond the filing limit will be rejected and members may not be billed for the services.

Electronic Claims Submission

Molina Healthcare accepts claims electronically. Electronic submission allows claims to be directly entered into Molina Healthcare's processing system, which results in faster payment and fewer rejections. Contact Molina Healthcare's Help Desk to sign up for ePortal at 1-866-449-6848 or contact your Provider Services Representative.

- ePortal (www.molinahealthcare.com) Provider Self Services
 - submit claims
 - status claims
 - print claims reports



Molina Healthcare also accepts electronic claims submissions through the following clearing houses:

- Netwerkes.com
- Emdeon (formerly WebMD) – Payer Number is 38334.
- Availity/THIN- Payer Number is 38334
- Payer Path (HCFA 1500 only) – Payer Number is 38334
- Practice Insight (HCFA 1500 only) – Payer Number 38334
- ZirMed Inc – Payer Number 38334
- SSI Group

Claims Form

- Professional charges must be submitted on a CMS 1500 08-05 version Form
- Facility UB04 Form

Paper Claim Submission Guidelines

- Must use original forms
- Must be typewritten or computer generated
- Do not use highlighters, white-out or any other markers on the claim
- Avoid script, slanted or italicized type. 12 point type is preferred
- Do not use an imprinter to complete any portion of the claim form.
- Do not use punctuation marks or special characters
- Use a six digit format with no spaces or punctuation for all dates (ex 060101).
- Securely staple all attachments. Attachments should identify patient's name and recipient ID number

Claims Policies

Adjudication

MHM adjudicates claims according to the State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-9 Diagnosis Code Book, CPT Code Book, HCPCS and Michigan Department of Community Health (MDCH) website www.michigan.gov when submitting a claim

Payment

- Contracted providers will be paid according to the terms of the agreement between the provider and Molina Healthcare
- Non-Contracted Providers will be paid for covered services according to the MDCH Medicaid fee schedule



Resubmission

- Providers may resubmit claims with correction(s) and/or change(s). The provider should document on the claim that the claim is being resubmitted.
- CMS 1500 claim form: Enter “RESUBMISSION” on the claim in the Remarks section.
- UB04 claim form: Type of bill must be indicated on the form. Enter “RESUBMISSION” in the comments section of the form.

Please send to Original/Resubmission address above. Faxed copies are no longer accepted.

Newborn Care

Newborn care must be submitted on the appropriate claim form using the newborn’s Medicaid ID number. The mother’s Medicaid ID number may not be used to bill for services provided to a newborn.



Provider National Identification Number (NPI)

Molina Healthcare Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Billing Provider Medicaid Number	Yes	Box 33b
Rendering Provider NPI	Yes	Box 24j
Rendering Provider Medicaid Number	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j; 33b and 32b
UB04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Billing Provider Medicaid Number	Yes	Box 57a
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76,77,78 and 79

Coordination of Benefits

As a provider treating Molina Healthcare members, your cooperation in notifying Molina Healthcare when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third party recovery for coordination of benefits, worker's compensation and subrogation.

- Claims involving coordination of benefits with primary insurance carriers should be received by Molina Healthcare within 365 days from the date of the primary carrier's explanation/denial of benefits.
- If Molina Healthcare reimburses a provider and then discovers other coverage is primary, Molina Healthcare may request the provider to refund the amount paid by Molina Healthcare.
- Regardless of the primary payer's reimbursement, Molina Healthcare should be billed as a secondary payer for all services rendered. A copy of the primary payer's EOB showing payment or denial must be attached to the claim.
- Molina Healthcare will make payment if the primary insurance payment is less than the Medicaid Fee for Service Rate.
- Molina Healthcare members cannot be billed for any outstanding balance after Molina Healthcare makes payment.
- Molina Healthcare members do not have deductibles, co-pays or co-insurance.



Appeals

Providers may submit an appeal by following the steps below:

- Contact the Claims Call Center at 1-888-898-7969, Option 1, then 2
- Speak to a Claims Resolution Representative. If you do not agree with the claims determination, then :
- Submit a letter of appeal detailing your reason for appeal along with supporting documentation within 90 days of your of the original claims determination
- Mail your appeal to:

Molina Healthcare of Michigan, Inc.
100 West Big Beaver Road, Suite 600
Troy, MI 48084-5209

Claim Form Field Requirements

- See Attachment A for CMS HCFA 1500 08-05 claim form requirements
- See Attachment B for CMS 1450 UB-04 claim form requirements

Sample Remittance Advice (RA)

- See Attachment C



CMS HCFA 1500 08-05 claim form requirements

- **MANDATORY:** Item is required for all claims. If the item is left blank, the claim cannot be processed.
- **CONDITIONAL:** Item is required if applicable. Your claim may not be processed if blank.

FIELD	STATUS	INFORMATION
1	CONDITIONAL	Insurance
1a	MANDATORY	Medicaid I.D. Number (When billing for a newborn, the newborn's Medicaid ID is required by MHM)
2	MANDATORY	Patient's Name
3	MANDATORY	Patient's Birth Date And Sex
4	CONDITIONAL	Insured's Name
5	CONDITIONAL	Patient's Address
6	CONDITIONAL	Patient Relationship To Insured
7	CONDITIONAL	Insured's Address
8	CONDITIONAL	Patient Status
9	CONDITIONAL	Other Insured's Name
9a	CONDITIONAL	Other Insured's Policy Or Group Number
9b	CONDITIONAL	Other Insured's Date Of Birth And Sex
9c	CONDITIONAL	Employer's Name Or School Name
9d	CONDITIONAL	Insurance Plan Name Or Program Name
10a	MANDATORY	Is Patient's Condition Related To Employment?
10b	MANDATORY	Is Patient's Condition Related To Auto Accident?
10c	MANDATORY	Is Patient's Condition Related To Other Accident?
10d	CONDITIONAL	Reserved For Location Use
11	CONDITIONAL	Insured's Policy Group Or Federal Employee Compensation Act (FECA) Number
11a	CONDITIONAL	Insured's Date Of Birth
11b	CONDITIONAL	Employer's Name Or School Name
11c	CONDITIONAL	Insurance Plan Name Or Program Name
11d	CONDITIONAL	Is There Another Health Benefit Plan?
12	CONDITIONAL	Patient's Or Authorized Person's Signature
13	CONDITIONAL	Insured's Or Authorized Person's Signature
14	CONDITIONAL	Date Of Current Illness, Injury Or Pregnancy
15	CONDITIONAL	If Patient Has Had A Same Or Similar Illness, Give First Date
16	CONDITIONAL	Dates Patient Unable To Work In Current Occupation
17	CONDITIONAL	Name Of Referring Physician Or Other Source
17a	CONDITIONAL	I.D. Number Of Referring Physician
17b	CONDITIONAL	10-digit NPI# of Referring Physician or Other Source
18	CONDITIONAL	Hospitalization Dates Related To Current Services
19	CONDITIONAL	Reserved For Local Use
20	CONDITIONAL	Outside Lab/Charges
21	MANDATORY	Diagnosis Or Nature Of Illness Or Injury
22	CONDITIONAL	Medicaid Resubmission Code And Original Reference



FIELD	STATUS	INFORMATION
		Number
23	CONDITIONAL	Prior Authorization Number
24a	MANDATORY	Date(S) Of Service
24b	MANDATORY	Place Of Service
24c	CONDITIONAL	Type Of Service
24d	MANDATORY	Procedures, Services Or Supplies
24e	MANDATORY	Diagnosis Code (Pointer)
24f	MANDATORY	Charges
24g	MANDATORY	Days Or Units
24h	CONDITIONAL	EPSDT/Family Plan
24i	MANDATORY	EMG-Emergency - Y Or N
24j*	MANDATORY	Rendering Provider ID #, Medicaid # and NPI#
24k	CONDITIONAL	Reserved For Local Use
25	MANDATORY	Federal Tax I.D. Number (Check Box/SSN Or EIN)
26	MANDATORY	Patient's Account Number
27	CONDITIONAL	Accept Assignment
28	MANDATORY	Total Charge
29	CONDITIONAL	Amount Paid
30	MANDATORY	Balance Due
31	MANDATORY	Signature Of Physician Or Supplier Including Degrees Or Credentials
32	CONDITIONAL	Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office)
32a	CONDITIONAL	10-digit NPI# of Service Facility Location
33	MANDATORY	Company Name as registered with IRS, Address, Zip Code, Phone # and PIN # (Medicaid ID # without Provider Type). MHM requires the name registered with the IRS to be submitted on line one in Box 33.
33a	MANDATORY	10 digit NPI# of Billing Provider
33b*	MANDATORY	Billing provider Medicaid ID#

*Taxonomy code not required

UB-04 claim form requirements

- **MANDATORY:** Item is required for all claim submissions.
- **CONDITIONAL:** Item is required if applicable.

FIELD	STATUS	INFORMATION
1	MANDATORY	Company Name as registered with the IRS, Address and Telephone Number
2		Blank
3	MANDATORY	Patient Control Number
4	MANDATORY	Type of Bill
5	MANDATORY	Federal Tax Number
6	MANDATORY	Statement Covers Period
7		Blank
8a	MANDATORY	Patient Name
9a-d	MANDATORY	Patient Address
10	MANDATORY	Patient Date of Birth
11	MANDATORY	Patient Sex
12	MANDATORY	Admission Start of Care Date
13	MANDATORY	Admission Hour (for inpatient only)
14	MANDATORY	Type of Admission
15	MANDATORY	Source of Admission (SRC)
16	CONDITIONAL	Discharge Hour
17	MANDATORY	Patient Status (Discharge Status)*
18-28	CONDITIONAL	Condition Codes (if applicable)
29-30	CONDITIONAL	ACDT State
31-34	CONDITIONAL	Occurrence Codes and Dates (if applicable)*
35-37	CONDITIONAL	Occurrence span code
38a-d	CONDITIONAL	Name and Address of the party responsible for the bill
39-41 a-d	CONDITIONAL	Value Codes and Amounts (if applicable)*
42	MANDATORY	Revenue Codes*
43	MANDATORY	Revenue Description
44	MANDATORY	HCPCS Code/Rates (if applicable)
45	MANDATORY	Date of Service for the Line Item
46	CONDITIONAL	Units of Service (if more than 1)
47	MANDATORY	Total Charges (by Revenue Code/HCPCS)
48	CONDITIONAL	Dollar Amount for Any Non-covered Services
49		Blank
50	MANDATORY	Payer Identification
51	MANDATORY	Provider Number: Medicaid ID Number without the Provider Type
52	CONDITIONAL	Assigned Release For Insurance Benefit
53	CONDITIONAL	Assignment Of Benefits
54	CONDITIONAL	Prior Payments (if applicable)
55	MANDATORY	Estimated Amount Due From Payer
56	MANDATORY	Billing Provider NPI#



FIELD	STATUS	INFORMATION
57	MANDATORY	Billing Provider Medicaid Number
58	CONDITIONAL	Name Of Insured
59	CONDITIONAL	Patient's Relationship To Insured
60	MANDATORY	Medicaid Recipient ID Number (When billing for a newborn, the newborn's Medicaid ID is required by MHM).
61	CONDITIONAL	Name Of Group Or Plan Through Which Health Insurance Is Provided
62	CONDITIONAL	Group Policy Number
63	CONDITIONAL	Pre-Cert Or Authorization Number
64	CONDITIONAL	Document Control Number
65	CONDITIONAL	Name Of Employer
66	MANDATORY	ICD-9 Principle Diagnosis
67a-q	CONDITIONAL	Other Diagnosis Codes (if applicable)
68		Blank
69	MANDATORY	Admitting Diagnosis (for Inpatient only)
70 a-c	CONDITIONAL	Patient Reason Diagnosis
71	CONDITIONAL	
72	CONDITIONAL	External Cause Of Injury ICD-9 Diagnosis Code
73		Blank
74	CONDITIONAL	Principle Procedure Code and Date
74 a-e	CONDITIONAL	Other Procedure Codes and Dates
75		Blank
76	CONDITIONAL	Attending Provider NPI#
77	CONDITIONAL	Operating Provider NPI#
78-79	CONDITIONAL	Other Provider NPI#
80	CONDITIONAL	Remarks (if applicable)

*Refer to Uniform Billing Manual for List of Codes



ATTACHMENT C

Sample Remittance Advice (RA)



Molina Healthcare, Inc.

Remittance Advice for

TAX ID#

Carrier: Molina Healthcare of Michigan

Paid Date: 08/05/2003

Check#

3 Claim Number#

Provider:

Control# 3008

Claim Line	Date of Service	Rev Code	CPT/HCPC	Modifier	Units	Billed Amount	Contract/Allowed Amount	Dis - Allowed	COB/Other Insurance	Other Disc/Int.	Paid Amount	Health Plan: FFS/CAP	Michigan Medicaid Claim Line Message(s)
1	07/18/2003	0	90782		1	10.00	2.47	7.53	0.00	0.00	0.00	CAP	
Summary of Claim #						10.00	2.47	7.53	0.00	0.00	0.00		
Message:													

4 Claim Number#

Provider:

Control# 3008

Claim Line	Date of Service	Rev Code	CPT/HCPC	Modifier	Units	Billed Amount	Contract/Allowed Amount	Dis - Allowed	COB/Other Insurance	Other Disc/Int.	Paid Amount	Health Plan: FFS/CAP	Michigan Medicaid Claim Line Message(s)
1	07/18/2003	0	99394		1	155.00	57.20	97.80	0.00	0.00	0.00	CAP	
2	07/18/2003	0	81025		1	15.00	5.37	9.63	0.00	0.00	0.00	CAP	
3	07/18/2003	0	81002		1	5.00	1.25	3.75	0.00	0.00	0.00	CAP	
4	07/18/2003	0	92551		1	35.00	9.89	25.11	0.00	0.00	9.89	FFS	
5	07/18/2003	0	86580		1	15.00	5.83	9.17	0.00	0.00	5.83	FFS	
6	07/18/2003	0	99173		1	35.00	0.00	35.00	0.00	0.00	0.00	FFS	
Summary of Claim #						260.00	79.54	180.46	0.00	0.00	15.72		
Message: Line 6. - Service not a plan benefit.													



Molina Healthcare, Inc.

Remittance Advice for

TAX ID#

Carrier: Molina Healthcare of Michigan

Paid Date: 08/05/2003

Check#

Summary of Check

Billed Amount	\$	540.00
Contract/Allowed Amount	\$	164.02
DisAllowed Amt	\$	35.00
COB/Other Insurance	\$	0.00
Other Disc or Interest	\$	0.00
Paid Amount	\$	31.44

Check Amount \$31.44

Summary of Advances

Advance Amount Paid on Date:	\$	0.00
Advances Paid to Date	\$	0.00
Amount Applied with this payment	\$	0.00
Balance	\$	0.00

If there are any questions, regarding this payment, please submit a written request within 30 days to:

Molina Healthcare of Michigan, Inc.
100 West Big Beaver, Suite 600
Troy, MI 48084

For telephone inquiries, contact (248) 925-1700 (local) or (888) 898-7969 (toll free).
Appeals must be written and sent within 30 days of receipt.

Molina Healthcare of Michigan is "live" with Netwerkes.com. If you are interested contact Netwerkes.com at (810) 385-1181.