



Nursing Facility Add-On Therapy Service

Prior Authorization and Claim Filing Process

Nursing Facility Add-On Therapy Services (NF Add-On Therapy Services), formerly known as Goal Directed Therapy (GDT), must be prior authorized, using only the designated CPT/HCPCS codes from the Texas Department of Aging and Disability Services (DADS) LTC Crosswalk.

Molina shall pay for Nursing Facility Add-On Services rendered to Members that are determined by Molina to be payable at the lesser of (i) Provider's billed charges, or (ii) the allowable amount payable under the applicable Medicaid Fee-For-Service Program fee schedule as set forth by the State of Texas in effect on the Date(s) of Service.

Claims for Nursing Facility Add-On Therapy Services must be filed within 95 days of the date of service. Molina will adjudicate clean claims for Nursing Facility Add-On Therapy Services no later than 30 days after the claim is received by Molina.

Prior Authorization requests and claims for Nursing Facility Add-On Therapy Service should include revenue codes, CPT/HCPCS codes and Modifiers from the DADS LTC Crosswalk. No other revenue codes, CPT/HCPCS codes or Modifiers will be accepted.

Department of Aging and Disability Services LTC Crosswalk (Nursing Facility - excerpt)

Service	Revenue code	CPT/HCPCS	Modifiers
OT Rehabilitative Service	0431	97039	U1, UA
PT Rehabilitative Service	0421	97039	U1, UA
ST Rehabilitative Service	0441	92507	U1, UA
OT Rehabilitative Service Contracted	0431	97039	U1, UA,GO
PT Rehabilitative Service Contracted	0421	97039	U1,UA,GP
ST Rehabilitative Service Contracted	0441	92507	U1,UA,GN

Nursing Facilities (NF's) may submit claims on behalf of employed therapists (e.g., therapists who have the same National Provider Identification (NPI) and tax identification number as the NF) or contracted therapist.

Molina cannot accept therapy claims through its portal that are submitted by a contract therapist who is not a Medicaid enrolled provider.

Rates for Nursing Facility Add-On Therapy Services can be found using the following link to the Texas Health and Human Services Commission:

<https://rad.hhs.texas.gov/sites/rad/files/documents/long-term-svcs/2008/2008-nf-rehab-ss-rates.pdf>



Nursing Facility Add-On Therapy Services Prior Authorization

A Prior Authorization request for Nursing Facility Add-On Therapy Services may be made via fax (866) 420-3639 or through the Molina Provider Portal.

The use of the Molina Provider Portal is the preferred method of requesting a Prior Authorization.

An evaluation by the treating discipline should be completed prior to requesting an authorization. **No authorization is required for the initial evaluation.**

All authorizations will require supporting documentation to demonstrate medical necessity. Supporting documentation includes:

- Physician's order (a written telephone order is acceptable for initial request, but continued authorization requests will require a physician's signature)
- Therapy evaluation
- Additional supporting documentation as appropriate (examples: nurses notes, monthly summary, physician progress notes, fall history)
- Date and circumstances of an acute exacerbation of a chronic condition
- Diagnosis code
- Treatment CPT code with modifiers (only those on the DADS crosswalk as shown above)
- Number of visits/units
- Dates of Service – The start date must be the date of Prior Authorization request or later, no authorization can be issued for retroactive dates of service
- Continued Authorization Requests should include an updated plan of care

Copies of the Molina Healthcare of Texas Prior Authorization/Pre-Service Review Guide and the Molina Prior Authorization Form may be downloaded from the Molina Healthcare website:

Authorization form:

<http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/pa-guide-q4-2017.pdf>

2017 Q4 Prior Authorization Code Matrix

<http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/pa-matrix-q4-2017.pdf>

**Sample Prior Authorization Request Form submitted via fax with supporting documentation
for medical necessity of Nursing Facility Add-On Therapy Services**

Molina Healthcare/Molina Medicare Prior Authorization Request Form

Phone Number: (866) 449-6849

Fax Number: (866) 420-3639

MEMBER INFORMATION			
Date of Request:		4/30/15	
Plan:	Molina Medicaid	Molina Medicare	Other:
Member Name:	Resident's Name	DOB:	mo/ day /year
Member ID#:	Resident's Molina ID	Phone:	() Facility Phone Number
Service Type:	Elective/Routine	Expedited/Urgent*	

*Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

Referral/Service Type Requested			
Inpatient <input type="checkbox"/> Surgical procedures <input type="checkbox"/> ER Admits <input type="checkbox"/> SNF <input type="checkbox"/> Rehab <input type="checkbox"/> LIAC	Outpatient <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Diagnostic Procedure <input type="checkbox"/> Wound Care <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Rehab (PT, OT, & ST) <input type="checkbox"/> Chiropractic <input type="checkbox"/> Infusion Therapy	<input type="checkbox"/> Home Health <input type="checkbox"/> DME <input type="checkbox"/> In Office
Diagnosis Code & Description:	Full Diagnosis code & description as related to need for therapy		
CPT/HCPC Code & Description:	Use CPT Codes from DAD's crosswalk as noted previously		
Number of visits requested:		Date(s) of Service:	Expected date span of therapy, starting date may not be before submission of date of prior auth request

Please send clinical notes and any supporting documentation with this request

PROVIDER INFORMATION			
Requesting Provider Name:		Name of Nursing Facility or Individual Therapist if billing individually	
Contact at Requesting Provider's office:		Preferred contact to be the treating therapist	
Phone Number:	xxx-xxx-xxxx	Fax Number:	xxx-xxx-xxxx
TIN/NPI:	Matching the Requesting Provider	ADDRESS:	Matching the Requesting Provider
Provider/Facility Providing Service:	Name of Nursing Facility or Individual Therapist if billing individually		
Phone Number:	()	Fax Number:	()
TIN/NPI:	Matching Provider/Facility Providing Service		

For Molina Use Only:

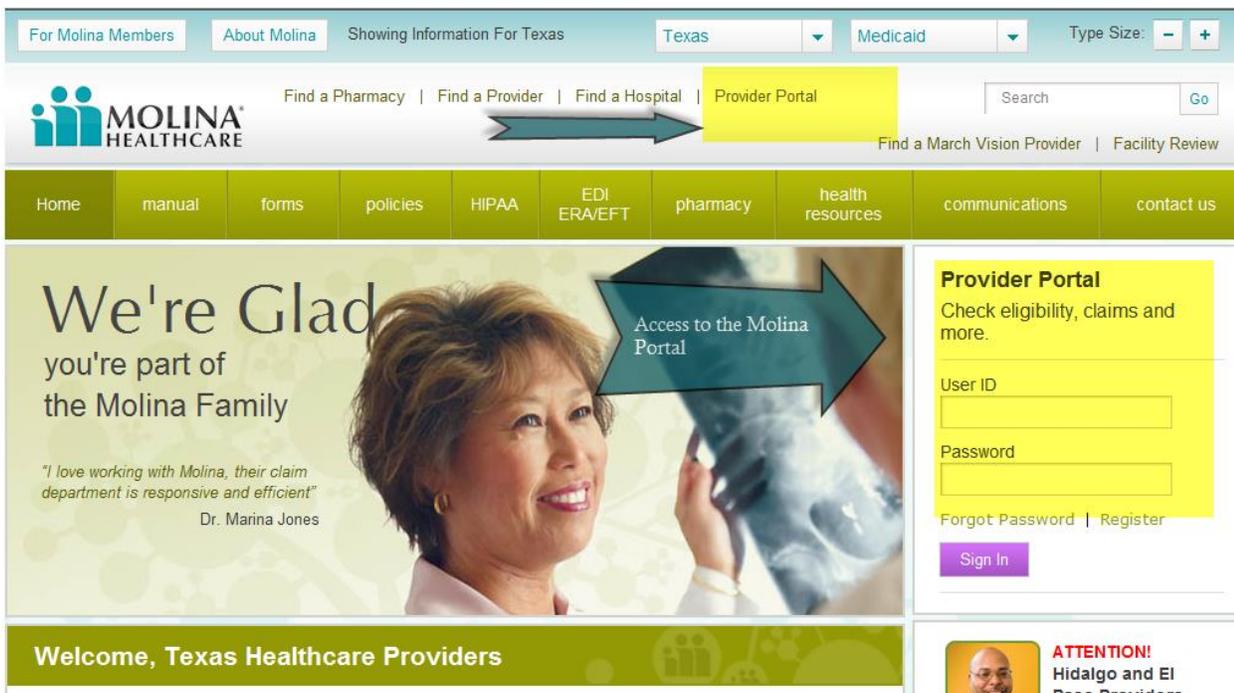
MolinaHealthcare.com

Prior Authorization Request for NF Add-On Therapy Services via the Molina Provider Portal

The preferred method to request a Prior Authorization is through the Molina Provider Portal.

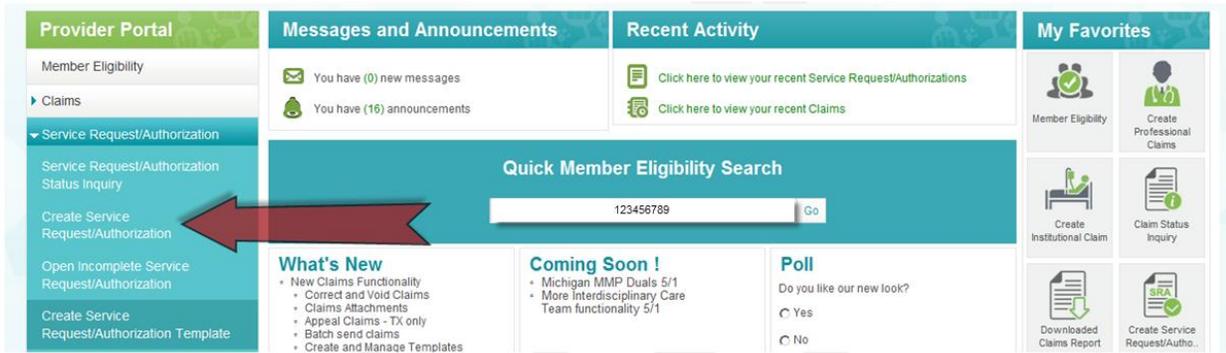
Access the Molina Provider Portal: <http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx>

- Log Into the Provider Portal or if necessary, Register
- **Note:** If the Nursing Facility has already been set up on the Provider Portal, you may request access/log in from the designated Portal Administrator in the nursing facility. You can make this request from the Molina Portal log in screen.



The screenshot shows the Molina Provider Portal website. At the top, there is a navigation bar with links for "For Molina Members", "About Molina", and "Showing Information For Texas". Below this is a search bar with "Texas" selected and "Medicaid" as the plan type. A large blue arrow points to the "Provider Portal" link in the navigation menu. The main content area features a banner with the text "We're Glad you're part of the Molina Family" and a quote from Dr. Marina Jones. A large blue arrow points to the "Provider Portal" link in the banner. To the right, there is a "Provider Portal" login form with fields for "User ID" and "Password", and a "Sign In" button. Below the banner, there is a "Welcome, Texas Healthcare Providers" message and an "ATTENTION!" notice for Hidalgo and El Paso Providers.

Instructions to Create a Nursing Facility Add-On Therapy Prior Authorization Request via Provider Portal



The screenshot shows the Provider Portal interface. On the left is a navigation menu with options like 'Member Eligibility', 'Claims', and 'Service Request/Authorization'. A red arrow points to 'Create Service Request/Authorization'. In the center is a 'Quick Member Eligibility Search' bar with the number '123456789' and a 'Go' button. Below the search bar are sections for 'What's New', 'Coming Soon!', and a 'Poll'.

- Quick Member Eligibility Search – Enter *Member's Medicaid ID Number*
- Select - *Create Service Request/Authorization*

1. All out of network services require Prior Authorization (PA); you may submit PA requests through ePortal. 2. Initial consults to Molina contracted Medical providers are direct referrals and do not require PA. Please do not submit direct referrals through ePortal.

Service Request/Authorization Form

* - Required Field

Member Search

Member ID: *

Eligibility information is current as of May 06 2015 04:42:47 AM PST ?

or

Last Name: * First Name: * Date Of Birth: * mmddyyyy

Patient Information

This section will automatically populate when you enter valid information for Member Search.

Last Name	First Name	Middle Initial	Date of Birth	Sex
Resident Name will self populate	ANNIE	M	12/02/1950	F
Address		City	State	Zip Code
Address will self populate		HOUSTON	TX	77049
Phone # (Home)	Phone # (Mobile)	PCP Name		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

- Member demographics will populate based upon *Quick Member Eligibility Search*
 - Member ID is the Member's *Medicaid ID Number*

Service Information

Enter Required Information*

Type of Service : * Therapies Submit Date : 05/06/2015

Place of Service : * Outpatient Inpatient Notification : * Select

Proposed Start Date : * 06/01/2015 Admission Date : * mmmddyyyy Discharge Date : * mmmddyyyy

Care Type : Elective Urgent/Expedite Within 72 Hours Emergency **Only choose a CARE TYPE if other than a ROUTINE submission**

Reason For Urgent/Expedite:

[Remove]	Diagnosis Code		Diagnosis Description
<input type="checkbox"/>	438.0		COGNITIVE DEFICITS-CEREBRVASC DZ
<input type="checkbox"/>	728.2		MUSCULAR WASTING and DISUSE ATROPHY NEC
<input type="checkbox"/>	V41.8		OTHER PROBLEMS W SPECIAL FUNCTIONS

(Add more diagnoses)

[Remove]	Procedure Code		Procedure Description	Number of Units	Procedure Modifier
<input type="checkbox"/>	97039		PHYSICAL THERAPY TREATMENT	1	u1 ua
<input type="checkbox"/>	92507		SPEECH HEARING THERAPY	1	u1 ua

(Add more procedures)

- Type of Service - Select *Therapies*
- Place of Service -Select *Outpatient*
- Proposed Start Date – The start date must be the date of Prior Authorization request or later, no authorization can be issued for retroactive dates of service
- Care Type – Select *Elective* (will be processed within 72 business hours)
- Reason for Urgent/Expedite - Leave blank
- Diagnosis Code – Enter the diagnosis to support the medical necessity of the requested therapy – search option may be used – will auto populate Diagnosis Description
- Procedure Code – Enter Procedure Codes for therapy using DADS LTC Crosswalk codes only – no other codes are acceptable *NOTE: Code for PT and OT is the same, thus description will be the same, therefore the number of units requested must be combined. Clarify number of PT units requested and number of OT units requested in the remarks field.*
- Number of Units – Enter number of requested units (unit equals one treatment day)
- Procedure Modifier – Enter Modifier using the DADS LTC Crosswalk code only, as shown below

Service	Revenue code	CPT/HCPCS	Modifiers
OT Rehabilitative Service	0431	97039	U1, UA
PT Rehabilitative Service	0421	97039	U1, UA
ST Rehabilitative Service	0441	92507	U1, UA
OT Rehabilitative Service Contracted	0431	97039	U1, UA, GO
PT Rehabilitative Service Contracted	0421	97039	U1, UA, GP
ST Rehabilitative Service Contracted	0441	92507	U1, UA, GN

Provider Information * - Required Field

Requester Information
 Name : HEALTHCARE & REHABILITATION EAST HOUSTON Phone # : 28145764...

Contact Information
 Name : * Rehab Personnel Phone # : * 281.555.5555 Fax # :

Accident Related Information
 Accident Code : Select Accident Date : mmmddyyyy

Pregnancy Related Information
 Last Menstrual Date : mmmddyyyy Estimated Date of Delivery : mmmddyyyy

Other Condition Related Information
 SELECT CONDITION
 Chiropractic Required when healthcare services is requesting chiropractic certification
 DME Required when healthcare services is requesting durable medical equipment
 Oxygen Therapy Required when healthcare services is requesting oxygen therapy certification
 Function Limitation Required when the assessing provider has defined function limitation for the patient
 Permitted Activities Required when the assessing provider has defined activities permitted for the patient
 Mental Status Required when the patient mental status is relevant to the health care services review

- Requester Information – Enter *Name of Nursing Facility* and phone number
- Contact Information – Enter *Name of Requesting Therapist* and phone number
- Accident Related Information – Select from drop down box if applicable Enter date as applicable
- Pregnancy Related information – not required
- Other Condition Related Information – Select if appropriate

Referring Provider Information

Referring Provider : HEALTHCARE & REHABILITATION EAST HOUSTON

Last/Facility Name : HEALTHCARE & REHABILITATION EAST HOUSTON
 Address : Skilled Row
 Email : Phone : 281.555.5555
 NPI : 171454730
 City : HOUSTON State : TX Zip Code : 77049
 Fax : Specialty : CUSTODIAL CARE FACILITY

Note: If you do not find the provider, please contact (866) 449-6849 for more information

Referred To Provider Information

To locate a provider enter the provider NPI and move to the next field to search or use the Find Provider link to select.
 If provider is not found, enter the required information manually. Find a Provider Clear

NPI : Last Name : Healthcare First Name : East Houston
 Address : City : Houston State : TX Zip Code :
 Email : Phone : Fax : Specialty : Select

Additional Provider Access Find a Provider

PCP NPI : PCP Last Name : PCP First Name :
 NPI : Last Name : First Name :
 (Add more providers) Delete

- Referring Provider Information – Enter *Nursing Facility NPI*
- Referred to Provider Information – Enter *Nursing Facility NPI* or manually enter fields required
- Additional Provider Access – Do not need to complete

Refer To Facility Information

To locate a facility enter the facility NPI and move to the next field to search or use the Find Facility link to select. If facility is not found, enter the required information manually.

Facility Name: TRANSITIONAL CARE CENTER

NPI: 1283735209

Address: 2109 SOUTH K STREET

City: MCALLEN

State: TX

Zip Code: 78503

Phone: 361669100

Fax: [Empty]

Specialty: [Select]

Supporting Information

You may attach documentation or note in the Clinical Notes/Comments section for your Service Request/Authorization.

Attachments

Type of Attachment: [Select]

File: [Browse... Upload]

Upload files only when you want to submit the Service Request/Authorization. Upload up to 5 files at a time that do not exceed a total of 5 MB and continue uploading until you complete the attachments. Each uploaded file cannot have more than 10 pages in the file. Each uploaded file size cannot be greater than 5 MB. The total attachment upload cannot exceed 20 MB

Clinical Notes/Comments

8000 Characters Max. 8000 characters remaining

Remarks: [Text Area]

- Referred to Facility Information will self-populate with entry of NPI
- Documents which support medical necessity
 - Physician's order (a written telephone order is acceptable for initial request, but continued authorization requests will require a physician's signature)
 - Therapy evaluation
 - Additional supporting documentation as appropriate (examples: nurses notes, monthly summary, physician progress notes, fall history)
 - Continued Authorization Requests should include an updated plan of care
- Remarks - Field supports up to 8000 characters for additional information
 - Recommend if requesting PT and OT in the same request, clarify in this field the request for both disciplines. The OT code is not a standard CPT/HCPCS for OT except with DADS LTC Crosswalk
- Once complete – Select *Submit*
- If you prefer to fax your documentation, once you submit the request, you will receive the following message:

Fax ✕

Do you have any supporting document to Fax?

CityV

- If YES is selected, you will receive a fax cover sheet to include with any Medical Documentation.
 - See example on next page

**Online Service Request
Supporting Document
Submission Form**

Instructions

1. Print this page
2. Do not write on or change anything on this page
3. Place this page in front of your supporting documentation
4. Fax this page along with your supporting documentation to this number:
Fax No: (866) 420-3639
5. Discard this cover sheet
DO NOT reuse this cover page for supporting documentation associated with a different service request

Submitted Tracking Number

State

CONFIDENTIALITY NOTICE

The documents accompanying this facsimile transmission contains confidential information belonging to the sender, which is privileged. The information is intended only for the use of the intended recipient, Molina Healthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of action in reliance on the content of this facsimile information is strictly prohibited. If you have received this facsimile in error, please immediately notify us via telephone at 1-866-665-4629. Thank you.

- Use the Molina provided coversheet to submit documentation via fax
 - This cover sheet is specific to this request and will automatically attach to the Authorization Request in the Molina Provider Portal

Prior Authorization Request Determination

Fax Request

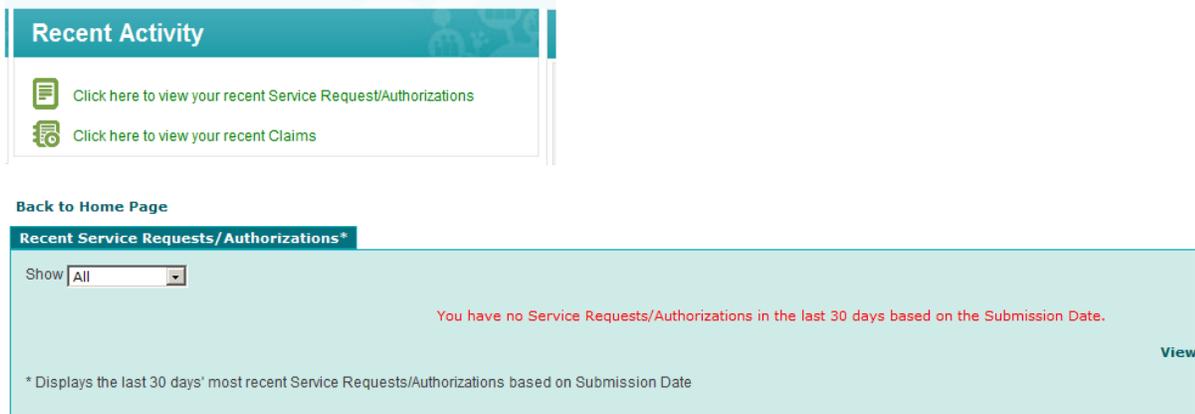
A Prior Authorization Request submitted via fax will not be available to view for status through the Molina portal.

If the request is “Denied” a Denial Letter will be mailed to the member and the provider. The Denial Letter will contain the exact reason for denial as well as information on how to appeal the denial.

Molina Provider Portal Request

A Prior Authorization Request submitted through the Molina Provider Portal can be monitored 72 hours after submission by viewing the Nursing Facility’s home screen and selecting *Click here to view your recent Service Request/Authorizations*.

If the request is “Denied” a Denial Letter will be mailed to the member and the provider. The Denial Letter will contain the exact reason for denial as well as information on how to appeal the denial.



The screenshot displays the Molina Provider Portal interface. At the top, there is a teal header with the text "Recent Activity". Below this header, there are two links: "Click here to view your recent Service Request/Authorizations" and "Click here to view your recent Claims", each accompanied by a small icon. Below the activity section, there is a link "Back to Home Page". The main content area is titled "Recent Service Requests/Authorizations*" and features a "Show" dropdown menu currently set to "All". A red message states: "You have no Service Requests/Authorizations in the last 30 days based on the Submission Date." A "View" link is located at the bottom right of this section. A footnote at the bottom left reads: "* Displays the last 30 days' most recent Service Requests/Authorizations based on Submission Date".



Claim Filing Instructions

Claims for Nursing Facility Add-On Therapy Services must be filed within 95 days of the date of service. Molina will adjudicate clean claims for Nursing Facility Add-On Therapy Services no later than 30 days after the claim is received by Molina.

Claims for Nursing Facility Add-On Therapy Service should reflect revenue codes, HCPCS/CPT codes and Modifiers from the Department of Aging and Disability Services (DADS) LTC Crosswalk. No other revenue codes, HCPCS/CPT codes or Modifiers will be accepted.

Department of Aging and Disability Services LTC Crosswalk (Nursing Facility - excerpt)

DESCRIPTION	CPT CODE	REVENUE CODE	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4
OT-REHABILITATIVE SERV	97039	0431	U1	UA		
OT EVAL HIGH COMPLEX	97167	0434	U1	UA	GO	
OT EVAL LOW COMPLEX	97165	0434				
OT EVAL MOD COMPLEX	97166	0434	U1	UA		
OT EVAL HIGH COMPLEX CONTRACTED	97167	0434	U1	UA	GO	KX
OT EVAL MOD COMPLEX CONTRACTED	97166	0434	U1	UA	GO	
OT EVAL LOW COMPLEX CONTRACTED	97165	0434	U1	GO		
PT-REHABILITATIVE SERV	97039	0421	U1	UA		
PT EVAL HIGH COMPLEX	97163	0424	U1	UA	GP	
PT EVAL LOW COMPLEX	97161	0424				
PT EVAL MOD COMPLEX	97162	0424	U1	UA		
PT EVAL HIGH COMPLEX CONTRACTED	97163	0424	U1	UA	GP	KX
PT EVAL LOW COMPLEX CONTRACTED	97161	0424	U1	GP		
PT EVAL MOD COMPLEX CONTRACTED	97162	0424	U1	UA	GP	

DESCRIPTION	CPT CODE	REVENUE CODE	MODIFIER 1	MODIFIER 2	MODIFIER 3	MODIFIER 4
ST-REHABILITATIVE SERV	92507	0441	U1	UA		
ST ASSESSMENT-REHABILITATIVE SERV	92521	0444	U1	UA		
ST ASSESSMENT-REHABILITATIVE SERV	92522	0444	U1	UA		
ST ASSESSMENT-REHABILITATIVE SERV	92523	0444	U1	UA		
ST ASSESSMENT-REHABILITATIVE SERV	92524	0444	U1	UA		
ST-REHABILITATIVE SERVICE CONTRACTED	92507	0441	U1	UA	GN	
ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	92506	0444	U1	UA	GN	
ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	92521	0444	U1	UA	GN	
ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	92524	0444	U1	UA	GN	
ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	92523	0444	U1	UA	GN	
ST-ASSESSMENT-REHABILITATIVE SERVICE CONTRACTED	92522	0444	U1	UA	GN	

Nursing Facilities (NF's) may submit claims on behalf of employed therapists (e.g., therapists who have the same National Provider Identification (NPI) and tax identification number as the NF) or contracted therapist.

Molina cannot accept therapy claims through its portal that are submitted by a contract therapist who is not a Medicaid enrolled provider.

Rates for Nursing Facility Add-On Therapy Services can be found using the following link to the Texas Health and Human Services Commission:

<https://rad.hhs.texas.gov/sites/rad/files/documents/long-term-svcs/2008/2008-nf-rehab-ss-rates.pdf>

Completing a Claim on the Molina Provider Portal

Access the Molina Provider Portal: <http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx>

- From the Home screen select *Claims*
- Select *Create Institutional Claim (UB04)* (opens on *Member* tab)
 - Every field with an asterisk must be populated
 - Using the DAD's LTC Crosswalk, enter revenue code, CPT/HCPS code and corresponding modifiers for therapy services rendered.
 - Only the required fields must be completed:
 - *Insured's ID* or Last Name, First Name, DOB
 - *Patient relationship* (defaults correctly to "self")
 - *Other Insurance (Y or N)*
 - *Type of Bill* (select from drop down box)
 - *Admission Date* (date admitted to Nursing Facility)
 - *Admission Type* (select from drop down box)
 - *Admission Source* (select from drop down box)
 - *Admission Hour*
 - *Status* (Status will always be 30)
 - *Value Code* (leave blank)
 - *Patient Control Number* (Nursing Facility medical record number)
 - *Revenue Code Description* (per DADS LTC Crosswalk)
 - *HCPCS/HIPPS Rate Codes/HCPCS Modifiers*: (Use CPT/HCPCS and corresponding Modifiers from DADS LTC Crosswalk)
 - *Service date* (use first date of service)
 - *Service Units* (enter number of units delivered) - (unit equals one treatment day)
 - *Total Charges* (per unit charges according to HHSC established rates)
<http://www.hhsc.state.tx.us/rad/long-term-svcs/downloads/2008-nf-rehab-ss-rates.pdf>
 - *Assignment of benefits* (select from drop down box)
 - *Release of information* (select from drop down box)
 - *Treatment Authorization code* (same as prior authorization number)
 - *Principal diagnosis* (primary diagnosis related to therapy)
 - *Admit diagnosis* (diagnosis related to therapy)
 - *Attending Physician NPI* (Physician who wrote therapy order)
 - *Supporting Information* (No supporting information is needed when filing an initial claim)

Completed Claim example from Molina Provider Portal for UB04 Facility Claim

Member Tab

UB-04 Facility Claim

Next
Save as Template
Back To Claim Detail
Cancel

Member
Provider
Summary

(Fields marked with * are required fields) [Help](#) [FAQ](#)

What would you like to do? Create Claim Correct Claim Void Claim

Eligibility Check

Enter the Insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID:

OR

Last Name:

AND

Statement From Date: (mm/dd/yyyy)

Advanced Search

First Name:

Date of Birth: (mm/dd/yyyy)

Statement To Date: (mm/dd/yyyy)

Insured's Information

Last Name:

Insured's ID:

Address:

City:

Insured Group Number:

Information Self Populates after Eligibility Check

First Name:

DOB:

Address2:

State:

Employer Name:

Middle Initial:

Sex:

Zip Code:

Patient Information

NOTE: If Patient is the Insured, Patient Information will be automatically populated

Patient Relationship to Insured:

Other Insurance

Is there another Health Benefit Plan? Yes No

Type of Bill:

Patient Conditions

Patient Condition related to: Employment Yes No Auto Accident Yes No Other Accident Yes No

Admission Date: (mm/dd/yyyy) Admission Type: Admission Source:

Admission Hour: (0 - 23) Discharge Hour: (0 - 23) Status:

Condition Code: [Add Another Condition Code](#)

Occurrence Codes: [Add Another Occurrence Code](#) Occurrence Date: (mm/dd/yyyy)

Occurrence Span Codes: [Add Another Occurrence Span Code](#) Occurrence Span From: (mm/dd/yyyy) Occurrence Span To: (mm/dd/yyyy)

Value Code: [Add Another Value Code](#) Amount(\$):

➤ Select *Next* when *Member* tab is completed – will move to *Provider* tab

Provider Tab

Member

Provider

Summary

Previous

Next

Save as Template

Back To Claim Detail

Cancel

(Fields marked with * are required fields) [Help](#) [FAQ](#)

Billing Provider Information

Billing Provider:

Last Name	First Name	Middle Initial	TIN	NPI	Provider ID
<input type="text" value="Facility"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="Tax ID"/>	<input type="text" value="NPI"/>	<input type="text" value="QMP00004716205"/>
Address1	Address2				
<input type="text" value="Facility Address"/>	<input type="text"/>				
City	State	Zip Code	Phone Number	Fax Number	
<input type="text" value="Facility City"/>	<input type="text" value="TX"/>	<input type="text" value="70000"/>	<input type="text" value="800-555-5555"/>	<input type="text"/>	

Claim Information

Type of Bill *	Patient Control Number *	Medical Record Number	Document Control Number			
<input type="text" value="223"/>	<input type="text" value="1234566"/>	<input type="text"/>	<input type="text" value="15096979123"/>			

(Remove)	Revenue Code:	Revenue Code Description:	HCPCS/HIPPS Rate Codes/HCPCS Modifiers:	NDC:	Service Date: *	Service Units: *	Total Charges: *	Non-Covered Charges:
1	<input type="text" value="0421"/>	<input type="text" value="Physical Therapy - Visit C"/>	<input type="text" value="97039u1ua"/>	<input type="text"/>	<input type="text" value="03/01/2015"/>	<input type="text" value="3"/>	<input type="text" value="113.1"/>	<input type="text"/>

+ Add another Claim Line

Assignment of Benefits: Release Of Information:

Treatment Authorization Code: **Add Another Authorization Code**

Diagnosis Code(s) (DX) and POA Indicators: **Add Another Diagnosis Code**

Admit Diagnosis: Patient Reason For Visit Code: **Add Another Patient Reason for Visit Code**

Prospective Payment System Code (PPS Code):

External Cause of Injury (ECI) Code and POA Indicators: **Add Another ECI code**

Principal Procedure Date: (mm/dd/yyyy) Principal Procedure Code: **Add Another Procedure Code**

Physician Information

Attending Physician*

NPI*	First Name	Last Name *	Secondary Qualifier	Physician ID	Add Another Physician
<input type="text" value="1114989910"/>	<input type="text" value="DEEPAK"/>	<input type="text" value="PATEL"/>	<input type="text" value="Select"/>	<input type="text"/>	<input type="button" value="Add Another Physician"/>

Supporting Information

Type of Attachment :

File :

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Remarks

Clinical Notes or Comments: 256 character Max

256 characters remaining.

➤ Select *Next* when *Provider* tab is completed – will move to *Summary* tab

Summary Tab

The summary tab allows viewing and editing of all fields of the claim.



- *Expand All* opens up the claim for review and editing

Once the claim is complete, you will have the option to

- *Save For Later*
- *Submit*
- *Save for Batch*
- *Cancel*

Once submitted, an email notification will be sent acknowledging the claim with a claim number.

- The claim will not be immediately viewable within the Molina Provider Portal

If additional assistance is needed with filing a Nursing Facility Add-On Therapy Service claim, please contact:

- Your assigned Nursing Facility Provider Services Representative (NF PSR) via phone or email
- Or contact NFProviderServices@Molinahealthcare.com