Claim for Targeted Medical Care Form Instructions

The table below follows the Claim for Targeted Medical Care form by field number, field name/description, whether that field is required, and a brief description of the information that needs to be entered in that field and how it needs to be entered.

Accuracy is important. Please type. If handwritten, please print legibly and use only blue or black ink.

Use the original claim form or the downloadable version available on the AmeriHealth Caritas Iowa website at **www.amerihealthcaritasia.com**. If you have any questions about this form, contact Provider Services at **1-844-411-0579**.

Field number	Field name/description	Requirements	Instructions
Member information			
1	AmeriHealth Caritas Iowa ID number	Required	Enter the member's AmeriHealth Caritas Iowa ID number found on their identification card. The ID number consists of nine digits (example: 123456789). **Note:** Please do not include any dashes or punctuation within the ID number. We will also accept the member's Medicaid ID number, but we prefer you use the AmeriHealth Caritas Iowa ID number.
2	Member's name	Required	Enter the member's last name then first name as they appear on the card.
Provider information			
3	NPI provider number	Situational	Enter the provider's NPI. If you do not have an NPI, leave this field blank. **Note:** Please do not include any dashes or punctuation prior to or within the NPI provider number.
4	Provider name	Required	Enter the name of the provider.
5	Provider address	Required	Enter the address of the provider.
6	ZIP code	Required	Enter the ZIP code associated with the provider's address.
7	Medicaid ID number	Situational	The ten-digit Iowa Medicaid provider number, starting with X00. If you do not have a Medicaid ID number, leave blank.
8	Taxonomy code	Situational	Required if the NPI reported in Box 3 does not begin with an "X." In this case, enter the taxonomy code associated with the provider. If the NPI starts with "X00," leave this field blank.
9	Tax ID number	Required	Taxpayer Identification Number (TIN) and Employer Identification Number (EIN) are defined as a nine-digit number that the IRS assigns to organizations. The IRS uses the number to identify taxpayers who are required to file various business tax returns.
10	Other health insurance	Required	Indicate whether the member has other insurance that covers the services billed by checking "yes." If you check yes, list the name of the insurance carrier.

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11	Other health insurance denied	Situational	Required if the member has other insurance that has denied payment. Check "yes" if the member's other insurance has denied payment. Check "no" if the other insurance has made payment on the service provided.
12	Other health insurance payment	Situational	Required if a payment was made by insurance other than AmeriHealth Caritas Iowa for the services billed. Enter the total $ amount paid by the other insurance carrier. If more than one claim form is used to bill for services, and a prior payment was made by insurance other than AmeriHealth Caritas Iowa, the prior payment should be entered on each page of the form. **Note:** The total must include both dollars and cents (example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
13	Client participation amount	Situational	Enter the deductible or copays due from the member by the other insurance carrier. If none, leave blank. If more than one claim form is used to bill for services and the member owes client participation (CP), the CP should be entered on each page of the claim in Box 13. **Note:** The total must include both dollars and cents (example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
Services			
14	Procedure code	Required	Enter the five-digit service code for each service being billed on the claim. **Note:** Please do not include any dashes or punctuation within the procedure code.
15	Modifier	Situational	Leave blank, except when the Notice of Decision indicates that a procedure code modifier is necessary.
16	Place of service	Required	Enter the two-digit place of service code of each service being billed on the claim. The place of service codes are listed page 2 of the form.
17	First date	Required	Enter the first date services were provided for the month being billed, in MM/DD/YY format. **Note:** Please wait until the month following the month services were provided to bill the claim. (Example: date of service 01/01/16 – 01/31/16, do not complete or mail until 02/01/16.)
18	Last date	Required	Enter the last date services were provided for the month being billed, in MM/DD/YY format. **Note:** A line can only contain services that took place in a single month. If services took place in multiple months, you must list the services provided in each month on separate lines. (Example: Line 1 — DOS 01/01/16 – 01/31/16; Line 2 — DOS 02/01/16 – 02/28/16.)
19	Units	Required	Enter the total number of units being billed for each line.

Field number	Field name/description	Requirements	Instructions
20	Total line charge	Required	Enter the total charge for each line. **Note:** The total must include both dollars and cents (example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
21	Total claim charges	Required	Enter the sum of the total line charges (Box 20). If more than one claim form is used to bill services performed, only the last page of the claim should give the claim total charge. The pages prior to the last page should have "continued" or "page_ of _" in Box 21. **Note:** The total must include both dollars and cents (example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
Authorized signature			
	Provider signature/ date	Required	The provider must sign and date the claim.
	Member signature/ date	**Required**	**The member must sign and date the claim. For consumer-directed attendant care claims only.**
Claim submission			
	Mailing the completed claim form	Required	Mail the completed claim form to: AmeriHealth Caritas Iowa P.O. Box 7113 London, KY 40742
Claim adjustment			
	Request for claim adjustment to a previous paper claim	Required	If submitting a request for adjustment to a previous paper claim, please write or stamp "corrected" or "resubmission" on the claim form. You can also request a claim adjustment by calling Provider Services at **1-844-411-0579** and selecting the appropriate prompts.

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