
The Following Reasons Are Causing Claims to Be Denied or Returned

- **If the rendering/servicing Provider Medicaid ID Number** is not entered in column 24K on the CMS-1500 claim form, your claim will be denied. When submitting a CMS-1500 claim form, column 24K must contain the rendering/servicing Provider Medicaid ID Number.

In Field 33 on the CMS-1500 claim form, the Provider Medicaid ID Number of the billing provider should be entered in the area marked GRP #. Do not enter the Provider Medicaid ID Number of the billing provider in the area marked PIN#.

- **If Medicare crossover claims** are submitted on the CMS-1500 claim form instead of on the Medicare Crossover Claim Form (FH-40), they will be returned to the provider for resubmission on the proper form. Medicare crossover claims can be processed only if submitted on the Medicare Crossover Claim Form (FH-40) as discussed in the Provider Training Workshops. This form is available on First Health Services' web site at <https://medicaid.nv.gov> by selecting "Forms" from the "Providers" drop down menu.
- **If Third Party payment amounts** are not reflected correctly on the claim form, your claim will be denied. Do not attach an EOB from another insurance carrier to your claim. If payment was received from another carrier, the amount paid must be entered in Field 29 on the CMS-1500 claim form. For UB-92 claims, enter the amount paid in Field 54, adjacent to the name of the third party payor in Field 50.
- **If the correct ADA claim form** is not used, your claim will be returned for resubmission on the proper form. There are different versions of the ADA claim form and they all have slight variations – however, the variations are significant enough to make the other versions scanner-unreadable. The only acceptable dental claim form is the ADA 1999, version 2000. "Dental Claim Form, © American Dental Association, 1999 version 2000" is shown in the top left corner of this claim form. If you submit your claim on any other ADA form, it will be returned for submission on the proper form.

The Following Reasons Will Delay the Processing Of Your Claim

Unnecessary attachments sent with a claim can delay the processing of your claim. We have received copies of Nevada Medicaid and Nevada Check Up cards, printouts of eligibility verification, medical reports and third party EOBs. As discussed during the Provider Training Workshops, the only claim attachments needed are (if applicable) the Sterilization Consent Form, Acknowledgement of Hysterectomy Information, Abortion Affidavit or Declaration, or a copy of the third party EOB only if the recipient has TPL and the primary insurance carrier denied the claim.

Procedure code descriptions are not necessary to process your CMS-1500 claims. Printing a description of the Procedure code on your claim form delays processing. First Health Services is receiving CMS-1500 claim forms where the description of the procedure being billed on a line (for example, line # 1) is being printed on the line below it (line # 2). This causes the claim to scan incorrectly.

Important Notice – Plastic Nevada Medicaid and Nevada Check Up cards

Plastic Nevada Medicaid and Nevada Check Up cards for recipients have been generated and will be mailed between October 9th and 15th. A new plastic Nevada Medicaid and Nevada Check Up card will be issued for each eligible recipient and will eventually replace the cardboard cards currently issued to recipients. If the recipient has two cards, both may be valid. The cardboard cards may be valid until the end of December 2003. The plastic cards are valid as long as the individual is qualified for medical assistance through Nevada Medicaid. At the present time, you may verify recipient eligibility through EVE. The EVES web address is <https://medicaid.state.nv.us>. The new Electronic Verification System (EVS) phone number, (800) 942-6511, will go into effect on October 20, 2003 at 6A.M.