Guidelines for Completing the Residential Claim Form

1. Bill *only* residential services (Room and Board, Care and Supervision, and Bed Holds) on the Residential Claim Form. All other services (including Respite) need to be billed on the General Services Claim Form. The use of the incorrect form will result in the denial of the claim.

2. **To avoid denial of claims**:
   - Use the correct form.
   - Complete and mail the form only after the last "To Date of Service" has passed.
   - Verify all information is accurate and complete.
   - Enter all required information per instructions.
   - Type/write legibly or complete the fillable claim form available online at www.carewisc.org on the "For Providers" page. Typed claims are preferred, as handwritten claims cannot be scanned and may cause delays in processing.
   - Bill in whole units, not fractions.
   - Enter dollar amounts to include cents (e.g. 254.78 or 234.00).
   - Bill only one month per line.

3. Please use the information in your Care Wisconsin Admission Agreement and the Service Authorization letter you received to complete this claim form. If you are uncertain about how to complete this claim form, it is essential that you contact the Care Wisconsin Provider Help Desk toll free at 1-855-878-6699 (Monday through Friday 8:00 am to 4:00 pm) prior to billing so you can receive assistance.

The following pages provide you with instructions on accurately completing a Care Wisconsin Residential Claim Form.
Please Keep for your records.

Care Wisconsin Residential Claim Form Instructions

Use the instructions below to complete your residential claim form. The numbers on the claim form correspond to the numbers on the instruction sheet.

New or Corrected:

Check the appropriate box to indicate whether this is a new claim or a correction to a prior claim which has been fully or partially paid.

Member Information Section:

1. Care Wisconsin Member Identification #: Enter the Care Wisconsin Member ID# as shown on the Admission Agreement including all digits (either six or nine).

2a. Member Last Name: Enter the Member's last name as shown on the Admission Agreement.

2b. Member First Name: Enter the Member's first name as shown on the Admission Agreement.

2c. Member Middle Initial: Enter the Member's middle initial as shown on the Admission Agreement, if applicable.

3. Member Date of Birth: Enter Member's date of birth as shown on Admission Agreement using the following format: MM/DD/CCYY (e.g. 04/02/2010 or 12/15/2010).

4. Diagnosis Code: Enter **R69** as the diagnosis code on **all** residential claim forms.

5. Admit Start Date: Enter the date the member began living at your facility or enrolled with Care Wisconsin, whichever is later.

6. Discharge Status:
   If the service is continuing enter the code:
   30 – Still a patient (Resident)

   If the facility is no longer serving the Member, enter one of the following codes:
   01 – Discharge to home or self-care – routine discharge
   02 – Discharged/transferred to hospital or inpatient care
   03 – Discharged/transferred to a skilled nursing facility
   04 – Discharged/transferred to an intermediate care facility
   05 – Discharged/transferred to another type of institution for inpatient care
   07 – Left against medical advice or discontinued care
   20 – Expired/Died

7. Type of Bill:
   Enter one of the 3 types of Bill Type Codes from the list below:
   0862 - 1st claim submitted (**first claim** submitted for a new resident)
   0863 - Billing a continuing claim (**ongoing stay**)
   0864 - Billing for the last claim (**last claim** submitted for a resident)

Provider Information Section:

8. Provider NPI: If you have a national Provider Identification Number (NPI), enter your number. If you do not have an NPI, leave blank.

9. Care Wisconsin Provider ID: Enter your Care Wisconsin Provider ID shown on the Admission Agreement, including the suffix if possible (e.g. 000001234-01).

10. Provider Tax ID: Enter the Tax Identification Number for your organization. The provider tax ID must match the ID provided on the W-9 form.

11. Provider Legal Name: Enter the name shown on the Admission Agreement as "Legal Name of Contracted Entity."

12. Billing Address: Enter the street address for Provider entered in #11 above.

13. City/State/Zip Code: Enter the City, State and Zip Code of the Provider entered in #11 above.

14. Service Location Name: Enter Service Location name as shown on Admission Agreement.

15. Service Location Address: Enter street address of Service Location entered in # 14.

16. City/State/Zip Code: Enter the City, State, and Zip Code of the Service Location entered in #14.

17. Date of Service:
    From Date: Enter the first date of service for the period you are billing for on this claim.

    To Date: If service is being provided every day with no breaks, enter the last date of service for the period you are billing for on this claim.

    If there is a gap in service, you must bill on separate lines for each continuous period of service, as "Dates of Service" must represent the actual dates the service was provided (see Figure 1). If there are breaks in service, each "To Date" is the last date the member slept in your facility for that billing period. If you need to bill for multiple months, please break them up into separate lines.

Figure 1

17. **Date of Service (MM/DD/YY)** (Date Span or Individual Days)		18. **Revenue Code**	19. **HCPCS Code**	20. **Service Description**	21. **Authorization Number**	22. **Units (# of Days)**	23. **Rate per Day**	24. **Total (Units X Rate)**
From Date	**To Date**							
4/02/15	4/15/15							
4/20/15	4/30/15							
								25. **Invoice Total**

18. Revenue Code:
    When billing for **Room and Board**, enter Revenue Code for Room and Board as shown on Admissions Agreement.

    When billing for **Care and Supervision**, enter Revenue Code for Care and Supervision as shown on Admissions Agreement.

When billing for **Bed Hold**, enter the Revenue Code listed in the table below that matches your facility type.

Table 1 - Bed Hold

Facility Type	Revenue Code	Service Description
AFH	0220	Bed Hold-Care and Supervision, AFH
CBRF	0229	Bed Hold- Care and Supervision, CBRF
RCAC	0221	Bed Hold-Care and Supervision, RCAC

19. HCPCS Code:
When billing for **Room and Board**, enter HCPCS code for Room and Board as shown on Admissions Agreement. If blank on Admissions Agreement, leave blank.

20. Service Descriptions:
When billing for **Room and Board,** enter "Service Description" as shown on Admission Agreement.

When billing for **Care and Supervision,** enter "Service Description" as shown on the Admission Agreement.

When billing for **Bed Hold,** enter "Service Description" shown in Table 1 – Bed Hold.

21. Authorization Number: Please enter the Authorization Number found on your Authorization Letter or on the MIDAS Authorization Portal (Family Care Members only).

22. Units (# of Days): See Figures 2, 3, 4 and 5 for examples.

Figure 2 – One month billing for continuous stay:
If there is no break in service and you will be continuing to serve the Member, enter the number of days that matches the range of dates beginning with the "From Date" and ending with the "To Date". (See line one in Figure 2)

17. **Date of Service (MM/DD/YY)** (Date Span or Individual Days)		18. **Revenue Code**	19. **HCPCS Code**	20. **Service Description**	21. **Authorization Number**	22. **Units (# of Days)**	23. **Rate per Day**	24. **Total (Units X Rate)**
From Date	**To Date**							
3/01/15	3/31/15					31		
								25. **Invoice Total**

Figure 3 – One month billing with break in service and service continuing in the next month:
If there is a gap in service, you must bill on separate lines for each continuous period of service, as "Dates of Service" must represent the actual dates the service was provided. For the first period of continuous service, enter the number of days that matches the range of dates beginning with the "From Date" to the "To Date". The "To Date" is the last date the Member slept your facility. (See Line 1 in Figure 3)

For the Second period of continuous service, enter the number of days that matches the range of dates beginning with the "From Date" and ending with the "To Date" (see Line 2 in Figure 3).

	17. **Date of Service (MM/DD/YY)** (Date Span or Individual Days)		18. **Revenue Code**	19. **HCPCS Code**	20. **Service Description**	21. **Authorization Number**	22. **Units (# of Days)**	23. **Rate per Day**	24. **Total (Units X Rate)**
	From Date	**To Date**							
Line 1	4/01/15	4/15/15					15		
Line 2	4/20/15	4/30/15					11		
									25. **Invoice Total**

Figure 4 – One month billing with discharge.

If the member was discharged, enter the number of days that matches the range of dates beginning with the "From Date" to the "To Date". The "To Date" is the last date the Member slept at your facility.

17. **Date of Service (MM/DD/YY)** (Date Span or Individual Days)		18. **Revenue Code**	19. **HCPCS Code**	20. **Service Description**	21. **Authorization Number**	22. **Units (# of Days)**	23. **Rate per Day**	24. **Total (Units X Rate)**
From Date	**To Date**							
4/01/15	4/29/15					29		
								25. **Invoice Total**

Figure 5 – One month billing with "Bed Hold".

If there is a gap in service, you must bill on separate lines for each continuous period of service, as "Dates of Service" must represent the actual dates the service was provided. For the first period of continuous service, enter the number of days that matches the range of dates beginning with the "From Date" to the "To Date". The "To Date" is the last date the Member slept in your facility. (See Line 1 in Figure 5)

Enter the "Bed Hold" range on a separate line. (See Line 2 in Figure 5)

For the Second period of continuous service, enter the number of days that matches the range of dates beginning with the "From Date" and ending with the "To Date". The "To Date" is the last date the Member slept in your facility. (See Line 3 in Figure 5.)

	17. **Date of Service (MM/DD/YY)** (Date Span or Individual Days)		18. **Revenue Code**	19. **HCPCS Code**	20. **Service Description**	21. **Authorization Number**	22. **Units (# of Days)**	23. **Rate per Day**	24. **Total (Units X Rate)**
	From Date	**To Date**							
Line 1	4/01/15	4/15/15					15		
Line 2	4/16/15	4/19/15					4		
Line 3	4/20/16	4/30/15					11		
									25. **Invoice Total**

23. Rates: Enter "Rate per Day" as shown on Admission Agreement for the type of service being billed on each line. Always include cents when entering dollar amounts (e.g. 14.75 or 14.00).

24. Total (Units X Rate): Multiply "Units" (column 21) and "Rate per Day" (column 22) and enter the total in Invoice Total (column 23) for each line. Always include cents when entering dollar amounts(e.g. 14.75 or 14.00).

25. Invoice Total: Add all numbers in column 23 and enter the total billed amount to be paid using two decimal points (e.g. 250.75).

26. Authorized Signature: Signature of person authorizing accuracy of claim.

    Print Name: Clearly print the name of the person signing the claim.
    Date: Enter the date the claim was signed by the authorized person.
    Phone Number: Enter the best contact number for any questions on the claim.

27. Mail completed form to: **Care Wisconsin**
    P.O. Box 226897
    Dallas, TX 75222-6897

Submitting a CORRECTED claim for a claim that has been fully or partially paid:

- For a **fully** or **partially** paid claim where the information submitted was incorrect, complete a new claim form with accurate information using the Care Wisconsin Residential Claim Form Instructions. The new claim form must include ALL services billed on the original submission, not just those services that are being changed. Bill the entire charge amount, not just any remaining balance, and we will adjust from the original claim.
- Check the "Corrected" box at the top of the form and include the claim number from the original claim, if possible.
- Mail corrected form to: **Care Wisconsin**
P.O. Box 226897
Dallas, TX 75222-6897

Re-submitting a claim that has been COMPLETELY denied:

For a **completely** denied claim where the information submitted was incorrect, prepare the claim with the correct information on a new claim form and submit the claim form in the normal way, checking the "New" box.

If your claim was partially or completely denied for reason other than incorrect information:

First, please contact the Provider Help Desk if you need clarification on the denial. If after checking with the Help Desk, you still believe that the denial or underpayment was in error, you may send a request for an appeal. You must submit your appeal in writing within 60 calendar days of the denial by sending a letter marked "Appeal" with specific information to:

Care Wisconsin
Attn: Claims Appeals
1617 Sherman Ave
Madison, WI 53704

Please visit our website for a copy of the Appeals Form:
http://www.carewisc.org/providers/claims#appealform