



County Indigent Health Care Program

SSI/Medicaid

Reimbursement

Manual

March 2016

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I. PURPOSE

- To assist counties that are not fully served by public hospitals or hospital districts in filing claims through the Texas Department of State Health Services (DSHS) County Indigent Health Care Group (CIHCG) for retroactive SSI/Medicaid reimbursement for County Indigent Health Care Program (CIHCP)-eligible individuals
- To give specific instructions for processing both prescription and medical claims
- To assist counties in maximizing Medicaid reimbursements
- To clarify non-reimbursable claims

II. REQUIREMENTS FOR PARTICIPATION

Confidentiality Agreement

- DSHS office must have a signed Confidentiality Agreement from a participating county prior to processing that county's Medicaid reimbursement claims.

Correct Forms

- Form 107, Hysterectomy Acknowledgment Statement
- Form 112, SSI Appellant Notification
- Form 113, Appellant/Provider Assignment
- Form 114, Confidentiality Agreement
- Form UB-04 (also known as CMS-1450)
- Form CMS-1500

Texas Title XIX Medicaid-Enrolled Providers

- Reimbursement through DSHS is for health care services in which the county paid a Texas Medicaid-enrolled provider.
- To verify Active Medicaid Pharmacies please visit:
<http://www.txvendordrug.com/providers/index.asp>

III. GENERAL PRINCIPLES

- Regardless of Medicaid reimbursement for services, Chapter 61 determines county responsibilities for services and procedures. Medicaid reimbursement should not interfere with Chapter 61 program requirements.
- In order for DSHS to process any Medicaid reimbursable claims, the county must follow CIHCP approved payment standards.
- DSHS cannot process claims received after the 95th day from the Medicaid “Add Date”
- DSHS must **enter** pharmacy claims within 365 days from the date of service
- DSHS must enter non pharmacy claims within 365 days from the date of service
- Medicaid reimbursements paid to the counties may be a lesser amount than the amount counties paid to the providers. Medicaid requirements may differ from those of CIHCP.
- DSHS requires immediate notification by the county when a provider reimburses the county on a claim that the county submitted to DSHS CIHCG. Counties should consult with providers to clarify filing procedures, if applicable.
- Do not send duplicate claims to be reimbursed by DSHS or by both DSHS and the local provider. If a provider will process the claim, do not send that particular claim to DSHS. Sending such a claim to DSHS could cause overpayment.
- Adjustments may occur due to contractor overpayments, duplicate payments, or other reasons. If there is an adjustment to a previous payment, DSHS will contact the county. The county is responsible for resolving the overpayment.
- On Form 105, Monthly Financial/Activity Report, deduct the SSI/Medicaid reimbursement amounts in the month received.
- In order for DSHS to process hospital claims, **counties must show their calculations on each entry in Block 47.**
- DSHS will notify counties regarding payment.
- Form 113, Appellant/Provider Assignment, must have the correct provider’s physical address, not the Post Office box address.

IV. MEDICAID VERIFICATION PROCESS

Counties may check Medicaid status by:

- Using the Automated Inquiry System (AIS) toll-free telephone number,
- Using the Texas Medicaid & Healthcare Partnership (TMHP) eligibility verification website,
- Reviewing the Medicaid eligibility letter from applicant/CIHCP-eligible individual; or
- Contacting the Social Security Administration office for eligibility details.
- [Contacting the DSHS for eligibility details.](#)

V. INSTRUCTIONS FOR CLAIMS SUBMISSION

General Requirements

- Submit **LEGIBLE** claims
 - Not cut off
 - Not faded
 - No notes obstructing required fields
- Claims must be received by DSHS within 95 days of the Medicaid Add Date **and**
 - pharmacy claims must be **entered** within 365 days from the date of service
 - non pharmacy claims must be entered by DSHS within 365 days from the date of service
- Only claims with dates of service within the Medicaid-eligible time period can be processed.
- One Form 112, SSI Appellant Notification, must be submitted for each provider.
- Each claim must be listed on Form 112.
- Separate the prescription drug claims from the medical claims.
- Separate claims by provider.
- Submit claims only when:
 - The corresponding Form 113 was signed by the appellant;
 - The corresponding Form 113 was signed by the provider **on or after** the date the appellant signed; and
 - The county paid the provider **on or after** the date the appellant and the provider signed the corresponding Form 113.

Requirements for Prescription Claims

- Separate claims by provider.
- List the amount paid for each prescription drug on separate lines and by date of service on the Form 112. Do not combine prescription drug payments by dates of service on the Form 112. **Do not list or send more than 3 prescription drug claims per appellant per month.**
- Attach copies of the prescription drug claims for each Form 112.
- Submit an appropriate Form 113 for each provider.
- Display only the Medicaid reimbursable client's name on the prescription claims.
- Ensure that each claim includes correct entries.
- Only prescription drugs listed on the Texas Vendor Drug website will be processed for payment. <http://www.txvendordrug.com/dw/FormularySearch.asp>
- Prescription claims must be paid according to the CIHCP approved payment formula located in the *CIHCP Handbook, Section Four, Service Delivery, Page 10*.

Requirements for Medical Claims

- Separate claims by provider.
- List the amount paid for each medical claim on separate lines and by date of service on Form 112. **Do not send claims that were not paid.**
- Attach copies of the claims for each Form 112.
- Submit an appropriate Form 113 for each provider.
- Ensure that each claim is on the correct form, UB-04 or CMS-1500, and that each claim includes correct entries.
- Ensure that calculations are completed on UB-04s.

VI. SPECIFIC FORM REQUIREMENTS

Prescription Drug Claims

Ensure that the following items are on each claim:

- Pharmacy Name and Physical Address
 - If pharmacy name and physical address are not printed on computerized printouts, the pharmacist or county must write the pharmacy name and the pharmacy's physical address on the computer printout.
- The client's name, the prescription drug's name, the Rx number, and the eleven-digit National Dispensing Code (NDC) number for each prescription drug.
- No more than three (3) prescription drugs per month per client.

NOTE: Supplies are not reimbursed, only prescription drugs. In addition, if there are more than three prescriptions filed per month, only the three most expensive will be submitted.

CMS-1500 Claims

Ensure that the following blocks are completed.

- Block No. **2** must have the patient name.
- Block No. **5** must have the patient address.
- Block No. **17** must have:
 - The ordering physician's name for laboratory services and for radiology services,
 - The referring physician/performing surgeon's name for services provided in an ambulatory surgical center (ASC) and
 - The referring physician's name for consultation services.
- Block No. **17b** must have the National Provider Identifier for the individual in Block 17.
- Block No. **21** must have at least one diagnosis code.
- Block No. **24A** must have only one date per line billed. Do not accept multiple (to-from) dates on a single line detail.
- Block No. **24A** must have the National Drug Code (NDC) qualifier of N4, followed by an 11-digit NDC number for physician-administered prescription drug procedure codes.
- Block No. **24B** must have the correct place of service. If the patient is registered at a hospital, the place of service must indicate inpatient or outpatient status at the time of service.
- Block No. **24D** must have procedure codes. Modifiers may be necessary. Anesthesia claims require the modifiers and the number of minutes. (Minutes are usually placed in the Block No. 24 area.)
- Block No. **24E** must have the diagnosis line item reference. Enter the line item reference for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block No. 21.
- Block No. **24F** must have the charges.
- Block No. **24G** must have the number of days or units.
- Block No. **31** must have the date and an **appropriate signature**.
 - **Handwritten signature (or signature stamp) of the provider or authorized representative or**
 - **“Signature on File” statement for claims prepared by computer billing services or office-based computers.**
- Block No. **32** must be completed if the place of service in Block No. 24B is anywhere other than the home or the provider's facility.
- Block No. **33** must have the Texas Medicaid Program billing provider name, address, phone number, National Provider Identifier (NPI), and Texas Provider Identifier (TPI).

Write the Medicaid payment rate for each CPT code listed, and write the per unit amount next to the rate, e. g., 10 units at the Medicaid payment rate of \$155.50 = 15.50 per unit.

UB-04 Outpatient Hospital Claims

Ensure that the following blocks are completed.

- Block No. **1** must have the provider name, address, and phone number.
- Block No. **4** must have the three-digit Type of Bill code.
- Block No. **8b** must have the patient name.
- Block No. **9** must have the patient address.
- Block No. **12** must have the date of service.
- Block No. **13** must have the admission hour.
(Admission hour is the time of treatment for outpatient claims.)
- Block No. **14** must have the type of admission code
- Block No. **15** must have the source of admission code
- Block No. **17** must have the patient status code
- Block No. **42** must have the revenue code
- Block No. **43** must have a description of the services.
- Block No. **43** must have N4, followed by the 11-digit NDC number for physician-administered prescription drug procedure codes.
- Block No. **44** may need a procedure (HCPC) code if warranted by the revenue code.
- Block No. **45** must have the dates of service.
- Block No. **46** must have the number of units of service.
- Block No. **47** must have the charges.
 - The charges must have the appropriate calculations completed by the county in Block 48 and divided by the number of units. (See Page 17 for detailed instructions.)
- Block Nos. **67A through 67Q** must have at least one ICD-9-CM diagnosis code.
- Block Nos. **76 through 79** must have the applicable physician information including national provider identifier.

Ensure that the Medicaid rate is written on the claim, e. g., 40%.

Ensure that the total amount paid is written on the claim and that the calculations for each procedure reflect this total.

Example:

Total Billed Amount \$500.00
Medicaid Rate 40%
Amount Paid \$200.00

UB-04 Inpatient Hospital Claims

Ensure that the following blocks are completed.

- Block No. **1** must have the provider name, address, and phone number.
- Block No. **3b** must have the medical record number.
- Block No. **4** must have the three-digit Type of Bill code.
- Block No. **6** must have the beginning and ending date of service.
- Block No. **8b** must have the patient name.
- Block No. **9** must have the patient address.
- Block No. **12** must have the admission date.
- Block No. **13** must have the admission hour.
- Block No. **14** must have the type of admission code.
- Block No. **15** must have the source of admission code.
- Block No. **16** must have the discharge hour.
- Block No. **17** must have the patient status code.
- Block No. **42** must have the revenue codes.
- Block No. **43** must have the description of the charges.
- Block No. **46** must have the number of units of service.
- Block No. **47** must have the charges.
 - The charges must have the appropriate calculations completed by the county in Block 48 and divided by the number of units. (See Page 15 for detailed instructions.)
- Blocks **67A through 67Q** must have at least one ICD-9-CM diagnosis code.
- Block **69** must have the admitting diagnosis code.
- **Blocks 72a through 72c must have applicable present on admission indicators in the shaded areas.**
- Block Nos. **74 through 74e** must have the principal and other procedure codes and dates. The provider must enter the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure code for each surgical procedure and the date each procedure was performed.
- Block Nos. **76 through 79** must have the applicable physician information including national provider identifier.

Ensure that the total amount paid is written on the claim and that the calculations for each procedure reflect this total.

VII. REIMBURSEMENT EXCLUSIONS AND LIMITATIONS

Exclusions

Services/Procedures that cannot be processed by DSHS are:

- Mammography
- Skilled Nursing Facility services
- Hospital lab procedures
- Rural Health Care Clinics
- Dates of service within Medicaid eligibility dates

Limitations

Some limitations in processing claims for Medicaid reimbursement are:

- Lab services will be filed only for physician and independent labs.
- If anesthesia, surgery, and assistant surgery claims are submitted for the same date of service for the same client, it is possible that only one of the procedures will be reimbursed.
- Outpatient hospital claims for physical therapy/occupational therapy (PT/OT) require modifiers.
- On a hospital claim with hysterectomy procedures, a Hysterectomy Acknowledgment Statement must accompany the claim.
- On a physician claim with hysterectomy procedures, one of the following must accompany the claim:
 - A Hysterectomy Acknowledgment Statement or
 - Documentation supporting that the Hysterectomy Acknowledgment Statement could not be obtained or was not necessary.
- A Federally Qualified Health Center (FQHC) is reimbursed by the CPT code rate.
- Outpatient hospital services with surgical procedures that were not an emergency are reimbursed at the ambulatory surgical center (ASC/HASC) rate.
- DSHS cannot process an anesthesia claim without an anesthesia modifier and a state defined modifier of U1 or U2.

VIII. DSHS PROCESS

After DSHS receives claims on cases, the following actions are taken:

- Verification of Medicaid eligibility dates, use of correct forms, and program requirements
- Separation of medical and prescription drug claims
- Processing of individual claims
 - Steps for Processing Prescription Drug Claims
 1. Verify claim requirements.
 2. Compute reimbursement amount to the county.
 3. Apply state payment procedures.
 4. Send reimbursement notification to the county.
 5. Comptroller reimburses the county.
 - Steps for Processing Medical Claims
 1. Verify claim requirements.
 2. Enter claim information and submit to claims contractor.
 3. Claim contractor submits to DSHS a Remittance and Status (R & S) Report, indicating payment status.
 4. Reconcile claims.
 5. Apply state payment procedures.
 6. Send reimbursement notification letter to the county. When all of the claims in the case have been reconciled, the word "Complete" will be on the letter.
 7. Comptroller reimburses the county.

IX. TABLES

PLACE OF SERVICE CODES
(Block 24B on CMS-1500)

1-Digit Numeric Codes (for Paper Billers)	Place of Service	2-Digit Numeric Codes (for Electronic Billers)
1	Office	11, 15, 50, 60, 65, 71,72
2	Home	12
3	Hospital, Inpatient	21, 51, 52, 55, 56, 61
4	Skilled Nursing Facility (SNF) Intermediate Care Facility (ICF) Intermediate Care Facility for Mentally Retarded (ICF-MR)	31,32,54
5	Hospital, Outpatient	22, 23, 24, 62
6	Independent Lab	81
7	Birthing Center	25
8	Extended Care Facility	33
9	Other Location	03,04,05,06, 07,08,26,34,41,42, 53, 99
Indicate destination using above codes	Destination of Ambulance	Indicate destination using above codes

**TYPE OF BILL CODES
Most-Commonly Used
(Block 4 on the UB-04)**

111 – Inpatient Hospital

131 – Outpatient Hospital

141 – Non-patient (laboratory or radiology charges)

731 – Federally Qualified Health Center (FQHC)

**CLAIM FORMS TO USE
(Depending on Service Provided)**

CMS-1500	UB-04
Advanced Practice Nurse	Ambulatory Surgical Center, Hospital-based
Ambulatory Surgical Center, Freestanding	Federally Qualified Health Center (FQHC)
Anesthetist	Hospital, Inpatient
Certified Nurse Midwife (CNM)	Hospital, Outpatient
Certified Registered Nurse Anesthetist (CRNA)	
Counseling (LCSW, LMFT, LPC, or Ph.D.)	
Durable Medical Equipment (DME)	
Federally Qualified Health Center (FQHC)	
Independent Laboratory	
Physician	

X. HELPFUL HINTS

Acronyms

AIS	– Automated Inquiry System
CIHCP	– County Indigent Health Care Program
CMS	– Centers for Medicaid & Medicare Services (previously HCFA)
CPT	– Current Procedural Terminology
DRG	– Diagnosis-Related Group
EOB	– Explanation of Benefits
HCFA	– Health Care Financing Administration (renamed CMS July 1, 2001)
HCPCS	– Healthcare Common Procedure Coding System
ICD-9-CM	– International Classification of Diseases, Ninth Revision, Clinical Modification
NPI	– National Provider Identifier
R & S	– Remittance and Status
SSI	– Supplemental Security Income
TMHP	– Texas Medicaid & Healthcare Partnership
UPIN	– Unique Physician Identification Number (for CMS) – Universal Provider Identification Number (for Texas Medicaid)

Processing Tips

- Since many of the CIHCP recipients later become Medicaid eligible, it is important that each CMS-1500 and UB-04 submitted has the correct Medicaid codes.

To ensure this, ask each provider to bill the county as if the provider were billing Medicaid **manually**, i. e., paper billing.

- Common reasons for non-entry of claims
 - Incomplete claim
 - Incomplete NPI. The NPI must have 10 digits. Check with the provider for their correct Medicaid billing number if you are unsure.

CALCULATIONS

Outpatient Hospital Claim

1. Multiply each entry in Block 47 by the percent rate. Write the result in Block 48.
2. Divide the amount by the number of service units. Write the result in Block 46.

Inpatient Hospital Claim Paid by Percent

1. Multiply each entry in Block 47 by the percent rate. Write the result in Block 48.
2. Divide this amount by the number of service units. Write the result in Block 46.

Inpatient Hospital Claim Paid by DRG

1. Divide the DRG amount by the total billed amount to come up with a percent.
2. Multiply each entry in Block 47 by the percent from Step 1. Write the result in Block 48.
3. Divide this amount by the number of service units. Write the result in Block 46.

XI. INTERNAL SSI MEDICAID AUDIT

- CIHCP will be conducting random quarterly internal audits of cases submitted by counties for SSI Medicaid Reimbursement.
- All counties submitting claims for SSI/Medicaid reimbursement will be reviewed at least once per fiscal year.
- Claims will be audited for correct payment methodologies and Medicaid reimbursement procedures outlined in this manual.
- Counties are responsible for all repayments identified through the audit.
- Failure to comply with DSHS audit procedures may result in DSHS' inability to file claim reimbursement for the county.
- Counties with high percentage errors identified through the internal audit will be required to fulfill additional requirements prior to claims processing. Requirements are listed below:
 - Level 1 – The county will be required to submit payment formulas for all claims in the next three cases submitted to DSHS for reimbursement. DSHS-CIHCG will review the payment formulas for errors.
 - Level 2 – The county will be required to re-calculate all payments submitted to and paid by CIHCG for the prior two quarters and refund any overpayments to the appropriate entity.
 - Level 3 – The county will be disqualified from the SSI/Medicaid Reimbursement process for six months.

XII. FORMS

The following forms must be used in processing claims through DSHS for SSI Medicaid reimbursement.

- Form 107, Hysterectomy Acknowledgment Statement, if applicable
- Form 112, SSI Appellant Notification
- Form 113, Appellant/Provider Assignment
- Form 114, Confidentiality Agreement

The Instructions to each of the above listed forms must be followed.

**COUNTY INDIGENT HEALTH CARE PROGRAM
HYSTERECTOMY ACKNOWLEDGMENT STATEMENT**
PROGRAMA DE ATENCIÓN MÉDICA PARA INDIGENTES DEL CONDADO
RECIBO DE INFORMACIÓN SOBRE LA HISTERECTOMÍA

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

Por la presente reconozco que me han informado, oralmente y por escrito, que una histerectomía (cirugía para sacar el útero) deja permanentemente incapaz de concebir hijos a la mujer a quien se le practica.

Signature – Client or Designated Representative/Firma – Cliente o Representante Designado/a

Date/Fecha

PURPOSE

To record that the patient was informed orally and in writing before a hysterectomy that she will be permanently incapable of bearing children.

PROCEDURE

Physicians inform the patient orally and in writing before a hysterectomy by reading the statement and asking the patient to sign one copy of Form 107.

A completed sterilization consent form may be used instead of the *Hysterectomy Acknowledgment Statement*, if all items on the form are completed.

Submit Form 107, or its equivalent, with the claim for SSI Medicaid reimbursement from DSHS.

DETAILED INSTRUCTIONS

Read the statement to the patient,

Allow the patient to read it, and

Have the patient or her representative sign and date it.

FORM RETENTION

Maintain the records relating to an application at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**This form is used only if the county is filing for
Texas Medicaid reimbursement through DSHS.**

PURPOSE

- To certify the county paid the claims listed and
- To claim Medicaid reimbursement for claims paid for CIHCP basic or some department-approved optional health care services provided by Texas Title XIX-enrolled providers.

Claims must be received by the CIHCG in Austin within 95 days of the Medicaid “add date” and within 365 days from the date of service. The “add date” is the date the appellant’s Medicaid eligibility is added to the computer system.

PROCEDURE

For the case record of each appellant who is determined retroactively eligible for Medicaid,

1. Separate claims into non-prescription services and prescription drugs.
2. Separate non-prescription claims by provider.
3. Separate prescription drug claims by provider.
4. Complete a separate Form 112 for each provider.

Make additional copies of Form 112, as necessary.

DETAILED INSTRUCTIONS

Check the appropriate box at the top of Form 112 to indicate whether the claim is for non-prescription services or for prescription drugs.

Complete the information about the appellant.

Complete the information about the provider.

List the amount paid for each claim on separate lines and in order by the Date of Service.

The county judge/designee must sign and date the certification at the bottom of each Form 112 submitted.

The county must complete the information about the county judge/designee at the bottom of Form 112.

To each Form 112, attach:

- The corresponding claims and
- One copy of the completed Form 113, Appellant/Provider Assignment.

FORM RETENTION

Maintain one copy of each completed Form 112 and all attachments at least until the end of the third complete state fiscal year following the date on which the reimbursement is received.

**COUNTY INDIGENT HEALTH CARE PROGRAM (CIHCP)
APPELLANT/PROVIDER ASSIGNMENT – CESIÓN DEL APELANTE Y DEL PROVEEDOR**

County	Telephone No.	Case Number
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APPELLANT ASSIGNMENT/CESION DEL SOLICITANTE DE SSI

<p>I certify that I am currently appealing the Social Security denial decision. As a condition of receiving CIHCP health care services, I give the above-named county my rights to recover the cost of health care services provided by the county from any third party, up to the amount of expenditures made on my behalf by the county.</p>	<p>Certifico que estoy apelando la decisión del Seguro Social. Como condición de recibir los beneficios de salud de CIHCP, cedo al condado nombrado arriba mi derecho a recobrar de cualquier tercera agencia o persona, el costo de servicios de salud provistos por el condado hasta cubrir los gastos incurridos por el condado o por TDH en beneficio mío.</p>	
<p>-----</p> <p align="center">Signature – Appellant/Firma – Solicitante de SSI</p>		
<p>-----</p> <p align="center">Date/Fecha</p>		
Name of Appellant/Nombre del Solicitante de SSI	Address (Street, City, State, ZIP)/Direccion (Calle, Ciudad, Estado, ZIP)	

PROVIDER ASSIGNMENT

<p>By signing this form, I agree to assign to the county my Medicaid reimbursement rights for services provided to this person and paid for by the county. I will not file claims with Medicaid for reimbursement of the county’s payments.</p>		
<p>In accepting this assignment, I agree to meet the following conditions:</p>		
<ul style="list-style-type: none"> • All claims I submit to the county must comply with all claims processing requirements for the Texas Medicaid Program. The claim forms will be imprinted in boldface type with the following statements: <ol style="list-style-type: none"> 1. “This is to certify that the foregoing information is true, accurate, and complete.” 2. “I understand that ultimate payment of this claim may be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.” <p>The statements may be printed above my signature or, if printed on the reverse of the form, a reference to the statements must appear immediately preceding my signature.</p> • Any costs for processing claims as a result of this assignment will not be passed along to the county. • I accept the amount paid by the county as payment in full for all services provided to the above-named appellant and I will not seek reimbursement for any difference between the amount paid by the county and the original billed amount from any person or entity. 		
<p>THIS ASSIGNMENT IS NULL AND VOID IF THE APPELLANT DOES NOT BECOME SSI MEDICAID ELIGIBLE.</p>		
<p>-----</p> <p align="center">Signature – Provider</p>		<p>-----</p> <p align="center">Date</p>
Provider’s Name	National Provider Identifier (NPI, the 10-character Medicaid Billing ID #)	Telephone No. ()
Physical Address (Street, City, State, ZIP)		

**This form is used only if the county is filing for
Texas Medicaid reimbursement through DSHS.**

PURPOSE

To certify the appellant's assignment of Texas Medicaid rights, and

To certify the provider's assignment of Texas Medicaid rights.

PROCEDURE

As necessary, make a copy of the Form 113 that has been signed and dated by the appellant. Issue a copy to each provider who submits claims to the county for services provided to the appellant.

Submit Form 113 to the CIHCG in Austin according to Form 112 Instructions.

DETAILED INSTRUCTIONS

County. The county completes the information blocks at the top of Form 113.

Appellant. The appellant completes, signs, and dates the Appellant Assignment portion of the form **before** the Provider Assignment is issued to the provider.

Provider. The provider completes, signs, and dates the Provider Assignment portion of Form 113 **prior** to the county paying the bill.

FORM RETENTION

Maintain the original Form 113s at least until the end of the third complete state fiscal year following the date on which reimbursement is received.

County Indigent Health Care Program Confidentiality Agreement

Staff Member's Name (Type or Print)	Title (Type or Print)
County	Telephone Number (Including Area Code)

The following agreement exists to ensure confidentiality, integrity, and continuity of information resources. This agreement applies to all information accessed through the Automated Inquiry System (AIS) or Texas Medicaid & Healthcare Partnership (TMHP).

Please read the following agreement thoroughly. Complete, sign, and date this form. Keep a copy for your records. Return the original to the Texas Department of State Health Services, County Indigent Health Care Group Mail Code 2831, PO Box 149347 Austin, TX 78714-9347.

I understand and agree that I may receive client-sensitive information from AIS/TMHP.

I understand and agree that I will use only AIS/TMHP to obtain the status of Medicaid eligibility dates in regards to the County Indigent Health Care Program.

I understand and agree that I will use only the assigned County Provider Identifier number to access AIS/TMHP.

I understand the importance of confidentiality and agree to keep any information received confidential.

I agree not to disclose any information to anyone or allow anyone to use this information.

I understand that I am responsible for my actions and the actions of any county staff member who may receive this information and who is under my direct control and supervision.

I understand and agree that in the event of an audit by Health and Human Services Commission (HHSC) and/or Texas Department of State Health Services (DSHS), the County will make available all documentation regarding Medicaid Reimbursement upon request.

I understand and agree that any questions concerning the appropriateness of the release of data will be processed according to DSHS policies and procedures for release of open records.

 Staff Member's Signature

 Date

 County Judge Signature

 Date

PURPOSE

To certify that the staff member who signs this agreement understands the intended use of all information accessed through the Automated Inquiry System (AIS) or Texas Medicaid & Healthcare Partnership.

PROCEDURE

Complete Form 114 prior to requesting processing of SSI Medicaid claims through the CIHCP in Austin.

DETAILED INSTRUCTIONS

Read the statement agreement;

Decide which staff member will be responsible for this function;

Have the responsible staff member and County Judge sign the form and;

Submit Form 114 to:

Texas Department of State Health Services
County Indigent Health Care Group, Mail
Code 2831, P.O. Box 149347 Austin, Texas
78714-9347

FORM RETENTION

Maintain a copy of Form 114 as long as SSI Medicaid reimbursements are being filed through the CIHCG in Austin or until a new staff member is responsible for this function.

DSHS County Indigent Health Care Program Claim Payment Verification – FY2009

The following case has been selected for an internal audit.

COUNTY	CLIENT	CASE RECORD NO.
---------------	---------------	------------------------

Payment verification for the claims listed below must be submitted within five business days upon receipt of request.

Type of Claim Reviewed	Name of Provider	Date of Service	Date Paid	Amount Paid
RX				

Payment Formula used to calculate the amount paid:

Type of Claim Reviewed	Name of Provider	Date of Service	Date Paid	Amount Paid
OUTPATIENT / INPATIENT				

Percent or DRG payment used:

REQUESTED BY:	DATE:
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PURPOSE

To request payment information for DSHS
Supplemental Security Income (SSI)
Medicaid reimbursement audit.

PROCEDURE

DSHS uses form to identify cases/files from counties. Counties will use the form to provide claim payment methodology and payment verification to DSHS. Verification may be in the form of copies of check, purchase order or voucher to provider.

DETAILED INSTRUCTIONS

Counties must complete the form providing payment methodology and fax the form and documentation to 512-776-7203 or

Mail to:
Texas Department of State Health Services
County Indigent Health Care Group, Mail
Code 2831, P.O. Box 149347 Austin, Texas
78714-9347