Medicaid Expansion Non-Emergency Transportation, Meals and Lodging Billing Form

Return completed form, along with invoices, to:

- Mail: Blue Cross Blue Shield of North Dakota
  Attn: Medicaid Expansion Claims
  4510 13th Avenue South
  Fargo, ND 58121

A typed form is preferred. If not, be sure to print clearly.

Refer to Pages 2–3 for data field explanations.

Medical Travel/Lodging Billing Information				
Member Information				
Member ID Number			Member Date of Birth	
Member First Name		Member MI	Member Last Name	
Provider Information				
Tax ID	Medicaid ID		Prior Authorization Number	
Provider Name				

Procedure Information				
Procedure 1				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				
Procedure 2				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				
Procedure 3				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				
Procedure 4				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				

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Procedure Information				
Procedure 5				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				
Procedure 6				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				
Procedure 7				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				
Procedure 8				
Date of Service	Procedure Code	Modifier	Units	Billed Amount
Comments				

Use Only When Correcting Claims	
Original Claim Number	☐ Void ☐ Replacement

Signature	
Signature	Date

Providers: Please retain a copy for your records.

Data Field Explanations

Section: Medical Travel/Meals/Lodging Billing Information

1. Member ID Number – A UMI consists of a three-digit alpha prefix preceding the 12-digit numeric UMI.
   a. Example: (Jane Doe YME123456789012)
2. Member Name – Name of the Member (first name, middle initial if applicable, last name)
   a. Member name must be their full legal name as identified on the members insurance card.
3. Member Date of Birth – Enter the member's date of birth in MM/DD/YYYY format.
4. Tax ID – Medicaid/Medicaid Expansion Provider tax ID Number.
5. Medicaid ID – a unique identifier assigned to providers who are enrolled in the Medicaid program.
6. Prior Authorization Number – Also known as Authorization Number.
   a. This number will be formatted starting with an "S" followed by 9 numeric digits (S123456789).
   b. This is required when submitting the claim form.
7. Provider Name – Name of the TML Provider (last name, first name, middle initial, or facility name).

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Section: Procedure Information

1. Date of Service – Date the service was provided.
    a. Date format example: MM/DD/YYYY.
2. Procedure Code – Five-digit code; a single alpha followed by four numeric or all numeric.
3. Modifier – Applicable modifier for the service provided.
    a. Example: TP modifier utilized when billing for unloaded miles.
4. Units – Number of services or miles
    a. When looking at the procedure code descriptions you may see number of units as two. That means one unit for the way to the appointment, one unit for the way back.
    b. When using procedure code S0215, do not include the first 15 miles. i.e.: total miles were 150-15=135 miles
5. Billed Amount – Total charge for the procedure line item.
    a. i.e.: If you bill A0100 for two units in the Procedure 1 field, the billed amount in the box should be the standard rate times two.
    b. If the charge is more than that, you will be reimbursed at the agreed upon rate.
6. Comments – Add Diagnosis Code Z59.5 (extreme poverty) in addition to any comments/descriptions of service, if applicable.

Section: Use Only When Correcting Claims

Only complete the section for Correcting Claims when applicable.

1. Original Claim Number – Number assigned during initial claim processing.
    a. This claim number is required when submitting a Replacement Claim Request.
2. Void – Check if requesting to void original claim number or Replacement – The replacement box needs to be checked if a correction needs to be made on a claim. Always check the original claim's processing first.

Section: Signature

1. Provider Signature – Provider's signature.
2. Provider Signature Date – Date signed.

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