471-000-129 Explanation of Deleted Medicaid Claims and Medicaid Claims In Process Over 30 Days Report (MCP564-DS)

This report (MCP564-DS) includes two sections: "Deleted Medicaid Claims" and "Medicaid Claims In Process Over 30 Days." It is mailed weekly to providers with institutional claims that meet the criteria for the report.

DELETED MEDICAID CLAIMS: This report section lists paper UB92/UB04 claims deleted from the Medicaid claims processing system the previous week.

Deleted claims are listed alphabetically by Medicaid client last name. If the Medicaid Client ID Number on the deleted claim is incorrect, the claim is listed on the report under "Unknown." If the Medicaid Provider Number on the deleted claim is incorrect, the claim does not appear on the report; a notice will be mailed to the address on the claim. Note: Deleted electronic claims are reported on the "Electronic Claim Activity Report" sent to the electronic claim submitter/clearinghouse.

Claims are deleted from the claim processing system because certain requirements prevent adjudication to final paid/denied status. The report lists each deleted paper claim and the reason(s) for deletion. A new, corrected claim must be submitted, if appropriate. If the deleted claim had attachment(s), the attachments must be included with the new claim.

Following is an example of the Deleted Medicaid Claims section with descriptions of key fields:

Key Field Descriptions:

1. Report Identifier 'D' indicates that this report lists deleted paper claims.
2. Indicates current envelope number and total number of envelopes for this provider number.
3. Medicaid Provider Number and Federal Tax Identification Number.
4. Provider Name and 'Pay to' Address.
5. Indicates this report is continued from a previous envelope.
6. Report Title.
7. Column Heading Information.
8. Medicaid Patient Last Name, First Name, Middle Initial.
9. Medicaid Recipient Number.
10. Date Claim Received.
11. Bill Type.
12. Provider Patient Account Number.
13. Medicaid Claim Number.

14. Service FROM and TO Dates.
15. Medicaid Delete Reason Codes and Descriptions.
16. Total Number of Claims Deleted.
17. Claim Submitted Amount.
18. National Health Care Claim Status Codes.
19. Total Submitted Amount.
20. Indicates this report is continued in additional envelopes.

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XXXXXXXX  XXXXXX                        STATE OF NEBRASKA                    REPORT PAGE 999,999
 MCP564-D                    HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT
 HH:MM PM MM/DD/CCYY
 ENVELOPE X OF X                                                                PROV PAGE   999,999

 STATE OF NEBRASKA CONTACT INFORMATION: MEDICAID INQUIRY
                                                  (402)471-9128
                                                  (877)255-3092

 FOR PROVIDER NUMBER: XXXXXXXXX-XX                                        FTIN: XXXXXXXXX

      PROVIDER BUSINESS NAMEXXXXXXXXXXXXXX
      PROVIDER PAY-TO NAMEXXXXXXXXXXXXXXXX
      ADDRESS1XXXXXXXXXXXX
      ADDRESS2XXXXXXXXXXXX
      CITYXXXXXXXXXXXXXXX XX 99999-9999

                                                              REPORT CONTINUED FROM ENVELOPE # X

*************************************************************************************************
                                               DELETED MEDICAID CLAIMS
                                                     WEEKLY REPORT
*************************************************************************************************
 * THE CLAIMS LISTED BELOW HAVE BEEN DELETED FROM THE NEBRASKA MEDICAID CLAIMS PROCESSING SYSTEM.
 * THESE CLAIMS ARE NO LONGER BEING PROCESSED. THE REASON FOR DELETION OF EACH CLAIM IS PROVIDED
 * REVIEW THE DELETION REASONS AND RESUBMIT A NEW CLAIM, IF APPROPRIATE. ALL REQUIRED DOCUMENTA-
 * TION MUST BE SUBMITTED WITH THE NEW CLAIM.
*************************************************************************************************
 RECIPIENT NAME                   RECIPIENT NBR   DATE RECD  TYPE PT ACCT NBR          CLAIM NBR
   SVC FROM    SVC TO              SUBMITTED AMT      508 REASON CODES
   DELETE REASON
 ------------------------------------------------------------------------------------------------
 LASTNAMEXXXXXXXXXXXX FIRSTNAMEX M 99999999999    MM/DD/YYYY XXX  PATACTNUMXXXXXXXXXX 00999999999
   MM/DD/YYYY  MM/DD/YYYY           9,999,999.99       XXXX  XXXX  XXXX
   XX - DELETE REASON DESCRIPTIONXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XX - DELETE REASON DESCRIPTIONXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XX - DELETE REASON DESCRIPTIONXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

             TOTAL CLAIMS DELETED: 999,999           TOTAL SUBMITTED AMOUNT: 9,999,999,999.99

 ******************************************END OF REPORT******************************************

                                                                   REPORT CONTINUED IN ENVELOPE # X
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MEDICAID CLAIMS IN PROCESS OVER 30 DAYS SECTION:

This report section lists paper and electronic institutional claims that are in process and were received at least 30 days prior to the report date.

Following is an example Medicaid Claims In Process Over 30 Days section of the report with descriptions of key fields:

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XXXXXXXX  XXXXXX                        STATE OF NEBRASKA                        REPORT PAGE 999,999
 MCP564-S                  HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT
 HH:MM PM MM/DD/CCYY
 ENVELOPE X OF X                                                                  PROV PAGE   999,999

 STATE OF NEBRASKA CONTACT INFORMATION: MEDICAID INQUIRY
                                                  (402)471-9128
                                                  (877)255-3092

 FOR PROVIDER NUMBER: XXXXXXXXX-XX                                          FTIN: XXXXXXXXX

      PROVIDER BUSINESS NAMEXXXXXXXXXXXXXX
      PROVIDER PAY-TO NAMEXXXXXXXXXXXXXXXX
      ADDRESS1XXXXXXXXXXXXX
      ADDRESS2XXXXXXXXXXXXX
      CITYXXXXXXXXXXXXXXX XX 99999-9999

                                                                REPORT CONTINUED FROM ENVELOPE #

*************************************************************************************************
 *                                  MEDICAID CLAIMS IN PROCESS OVER 30 DAYS                        *
 *                                              MONTHLY REPORT                                     *
*************************************************************************************************
 * THE CLAIMS LISTED BELOW HAVE BEEN IN PROCESS WITH NEBRASKA MEDICAID FOR OVER 30 DAYS. DO NOT *
 * RESUBMIT THESE CLAIMS.                                                                          *
*************************************************************************************************
 RECIPIENT NAME                    RECIPIENT NBR   DATE RECD       PT ACCT NBR          CLAIM NBR
   SVC FROM    SVC TO               SUBMITTED AMT
 ------------------------------------------------------------------------------------------------
 LASTNAMEXXXXXXXXXXX FIRSTNAMEX M 99999999999     MM/DD/YYYY      PATACTNUMXXXXXXXXXX
00999999999
   MM/DD/YYYY  MM/DD/YYYY            9,999,999.99

          TOTAL CLAIMS: 999,999                TOTAL AMOUNT: 9,999,999,999.99

*************************************END OF REPORT*******************************************

                                                                REPORT CONTINUED IN ENVELOPE # X
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Key Field Descriptions:

1. Report Identifier 'S' indicates that this report shows paper and electronic institutional claims in process over 30 days from date of receipt.
2. Indicates current envelope number and total number of envelopes for this provider number.
3. Medicaid Provider Number and Federal Tax Identification Number.
4. Provider Name and 'Pay to' Address.
5. Indicates this report is continued from a previous envelope.
6. Column Heading Information.
7. Report Title.
8. Medicaid Recipient Number.
9. Date Claim Received.
10. Provider Patient Account Number.
11. Medicaid Claim Number.
12. Medicaid Patient Last Name, First Name, Middle Initial.
13. Service FROM and TO Dates.
14. Total number of claims in process over 30 days.
15. Claim Submitted Amount.
16. Total Submitted Amount.
17. Indicates this report is continued in additional envelopes.