

RESIDENTIAL FACILITY CLAIM KEY

In order to process your claims accurately and timely, please refer to the information below when completing your claim forms. Incomplete claims may result in a delay in processing. Fields marked "*" are mandatory for processing.

| Field | What To Enter |
|-------------------------------------|--|
| Member/Client Name * | Name (first, middle initial and last) of NorthernBridges client |
| Member ID Number * | Client's NorthernBridges number (located on the authorization letter created by the Care Manager) |
| DOB | Clients date of birth (mm/dd/yyyy) |
| Gender | Male or female |
| Type of Bill (choose one)* | 861 - Respite services |
| | 862 - First claim for client |
| | 863 - Continuous claim for an ongoing stay |
| | 864 - Last claim for client |
| Billing Provider Name * | Name of billing facility |
| Billing/Remit Address * | Address where payment should be sent |
| City, State & Zip * | City, state and zip code of billing provider |
| Tax ID Number * | Federal Tax ID number or social security number under which you bill |
| NPI (if applicable) | National Provider Identifier (assigned to most providers of medical services, not residences) |
| Authorization Number | Number on the letter created by the Care Manager which authorizes services |
| Rendering Facility Name* | Name of facility where services were rendered |
| Rendering Facility Address* | Address of facility where services were rendered |
| City, State & Zip* | City, state and zip code of facility where services were rendered |
| Statement Period From * | First date of billing period; must be in mm/dd/yyyy format. |
| Statement Period To * | Last date of billing period; must be in mm/dd/yyyy format. |
| Admission Date | Original admission date to facility or residence |
| Discharge Status (choose one)* | 01 - Discharge to home or self-care (routine discharge) |
| | 02 - Discharged or transferred to hospital or inpatient care |
| | 03 - Discharged or transferred to a skilled nursing facility |
| | 04 - Discharged or transferred to an intermediate care facility |
| | 05 - Discharged or transferred to another type of institution for inpatient care |
| | 07 - Left against medical advice or discontinued care |
| | 20 - Expired/died |
| 30 - Still a patient (ongoing stay) | |
| HIPAA/Service Code * | HIPAA code provided by NorthernBridges which can be located on the letter that authorizes services. It must be a 4 or 5-digit/character code, with leading zero if applicable. |
| Modifier * (if applicable) | 2-digit/character code that provides specific information relating to HIPAA code (if applicable); located on the authorization letter after the HIPAA code. |
| Billing Period From Date * | Date services for which you are billing <u>began</u> ; must be in mm/dd/yyyy format. |
| Billing Period To Date * | Date services for which you are billing <u>ended</u> ; must be in mm/dd/yyyy format. |
| Number of Days/Units * | Number of units or days billed for the specific code listed on the service line; MUST BE <u>WHOLE</u> UNITS. |
| Rate per Day/Unit Amt. * | Dollar amount/rate per day or unit. |
| Total Billed Amount * | Billed amount for services on that line |
| Grand Total * | Total of all service lines |