



Medicaid Enterprise  
Department of Human Services

For Human Services use only:  
**General Letter No. 8-AP-317**  
Employees' Manual, Title 8  
Medicaid Appendix

March 11, 2011

**RURAL HEALTH CLINIC TRANSMITTAL NO. 11-1**

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **RURAL HEALTH CLINIC**, Chapter III, *Provider-Specific Policies*, Table of Contents, page 2, revised; pages 74, 75, and 76, revised; pages 77 through 84, new; and the following forms:

- Remittance Advice*, revised
- Part B Remittance Advice*, new
- Outpatient Crossover Remittance Advice*, new
- Capitation Remittance Advice*, new

**Summary**

This release adds samples of the *Remittance Advice* and updates the instructions.

**Date Effective**

Upon receipt.

**Material Superseded**

This material replaces the following pages in the **Rural Health Clinic Manual**:

<u>Page</u>	<u>Date</u>
<b>Chapter III</b>	
Contents (page 2)	May 1, 2008
74	May 1, 2008
Remittance Advice	10/19/07
75, 76	May 1, 2008

**Additional Information**

The updated provider manual containing the revised pages can be found at:  
[www.ime.state.ia.us/providers](http://www.ime.state.ia.us/providers)

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us).



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Note that claim credits or recoupments (reversed) appear as regular claims, with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one’s understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

## 2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

	Field Name	Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released

R.A. NO.: A  
00000000

WARRANT NUMBER: B  
00000000

C

PROVIDER NAME	D
PROVIDER ADDRESS	
PO BOX XXX	
ANYTOWN	IA 00000-0000

---- NEWSLETTER UPDATE ----

\*\*\*\*\*IMPORTANT IME INFORMATION\*\*\*\*\*

E

IMPORTANT INFORMATION AND REMINDERS FROM IME WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IMEPROVIDERSERVICES@DHS.STATE.IA.US

TO: **C** PROVIDER NAME R.A. NO.: **A** 0000000 WARR NO.: **B** 0000000 DATE PAID: **G** XX/XX/XX PROV. NUMBER: **H** 1234567890 PAGE: **I** 1

\*\*\*\* PATIENT NAME \*\*\*\* RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /  
 LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

\* \* \* CLAIM TYPE: HCFA 1500 \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
FIRST LAST Last First	1234567A	0-00000-00-000-0000-00	100.00	0.00	65.00	3.00	LF8888	000 000
	01 02 03	XX/XX/XX 99999 XX/XX/XX 9999X 25 XX/XX/XX 999XX	1 1 1	00.00 70.00 30.00	0.00 50.00 15.00	0.00 0.00 3.00	1234567890 1234567890 1234567890	Y F F 000 000 000 000 000 000
	10	11 12	13	14	15	16	17	18 19
<b>Q</b> 01 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..			100.00	0.00	65.00	3.00		
			<b>R</b>	<b>S</b>	<b>T</b>	<b>X</b>		

TO: C PROVIDER NAME DDS R.A. NO.: A 00000000 WARR NO.: B 00000000 DATE PAID: G MM/DD/YY PROV. NUMBER: H 0000000000 PAGE: I 2

REMITTANCE TOTALS					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">J</span> 0	-----	<span style="border: 1px solid red; padding: 2px;">K</span> 0,000.00	<span style="border: 1px solid red; padding: 2px;">L</span> 0,000.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDEd CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF EFT DEPOSIT:	-----				<span style="border: 1px solid red; padding: 2px;">M</span> 0,000.00

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

COUNT:

<span style="border: 1px solid red; padding: 2px;">N</span> <span style="border: 1px solid red; padding: 2px;">O</span> 000	<span style="border: 1px solid red; padding: 2px;">P</span> EXPLANATION (EOB) OF DENIAL CODE	<span style="border: 1px solid red; padding: 2px;">1</span>
---	--	---



	Field Name	Field Description
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total member copayment on claim
8	Med Rcd Num	Medical record number or patient account number



	Field Name	Field Description
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number
18	S	Source of payment. Allowed charge source codes are as follows: <ul style="list-style-type: none"> <li>A Anesthesia</li> <li>B Billed charge</li> <li>C Percentage of charges</li> <li>D Inpatient per diem rate</li> <li>E EAC priced plus dispense fee</li> <li>F Fee schedule</li> <li>G FMAC priced plus dispense fee</li> <li>H Encounter rate</li> <li>I Prior authorization rate</li> <li>K Denied</li> <li>L Maximum suspend ceiling</li> <li>M Manually priced</li> <li>N Provider charge rate</li> <li>O Professional component</li> <li>P Group therapy</li> <li>Q EPSDT total over 17</li> <li>R EPSDT total under 18</li> <li>S EPSDT partial over 17</li> <li>SP Not yet priced</li> <li>T EPSDT partial under 18</li> <li>U Gynecology fee</li> <li>V Obstetrics fee</li> <li>W Child fee</li> <li>X Medicare or coinsurance deductibles</li> <li>Y Immunization replacement</li> <li>Z Batch bill APG</li> </ul>

R.A. NO.: A  
00000000

WARRANT NUMBER: B  
00000000

C

PROVIDER NAME	D
PROVIDER ADDRESS	
PO BOX XXX	
ANYTOWN	IA 00000-0000

---- NEWSLETTER UPDATE ----

\*\*\*\*\*IMPORTANT IME INFORMATION\*\*\*\*\*

E

IMPORTANT INFORMATION AND REMINDERS FROM IME WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IMEPROVIDERSERVICES@DHS.STATE.IA.US

R E M I T T A N C E A D V I C E

TO: PROVIDER NAME R.A. NO.: 0000000 WARR NO.: 0000000 DATE PAID: XX/XX/XX PROV. NUMBER: 1234567890 PAGE: 1

\* PATIENT \* RECIPIENT TRANS-CONTROL-NUMBER / MCARE MCARE DEDUCT- COINS. MCAID MED RCD NUM /  
LAST F M IDENT NUM LINE SVC-DATE PROC MODS UNITS PAID AMT APPRD IBLE AMT. COPAY PAID AMT PERF-PROV. S EOB EOB

\* \* \* CLAIM TYPE: MEDICARE PART B CROSSOVER \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1 SMITH J	2 1043087B	3 3-09000-00-000-0000-00	4 4.00	5 30.00	6 15.00	7 0.00	8 1.00	9 15.00	10 XXXXXXXXJSM			
	01	XX/XX/XX	99999	1 4.00	30.00	15.00	0.00	1.00	15.00	X		
	11	12	13	14	15	16	17	18	19	20	21	22

1 CLAIMS - THIS CLAIM TYPE / CLAIM STATUS. TOTAL 4.00 30.00 15.00 0.00 1.00 15.00

Q R S T U V X

TO: C PROVIDER NAME DDS R.A. NO.: A 00000000 WARR NO.: B 00000000 DATE PAID: G MM/DD/YY PROV. NUMBER: H 0000000000 PAGE: I 2

REMITTANCE TOTALS			
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">J</span> 0 -----	<span style="border: 1px solid red; padding: 2px;">K</span> 0,000.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">L</span> 0 -----	0.00
AMOUNT OF EFT DEPOSIT:	-----		<span style="border: 1px solid red; padding: 2px;">M</span> 0,000.00

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

<span style="border: 1px solid red; padding: 2px;">N</span> <span style="border: 1px solid red; padding: 2px;">O</span> 000	<span style="border: 1px solid red; padding: 2px;">P</span> EXPLANATION (EOB) OF DENIAL CODE	<span style="border: 1px solid red; padding: 2px;">1</span>
---	--	---



Field Name		Field Description
		0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
19	EOB	Explanation of benefits denial reason code

### 3. Part B Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB



Field Name		Field Description
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Mcare Paid Amt	Total Medicare payment within same claim type or status
S	Mcare Apprd	Total Medicare approved within same claim type or status
T	Deductible	Total deductible amount within same claim type or status
U	Coins. Amt.	Total coinsurance amount within same claim type or status
V	Copay	Total copayment amount within same claim type or status
X	Mcaid Paid Amt	Total Medicaid payment within same claim type or status

1	Patient	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Mcare Paid Amt	Total paid by Medicare on claim
5	Mcare Apprd	Total amount Medicare approved
6	Deductible	Total Medicare deductible on claim
7	Coins Amt.	Total Medicare coinsurance on claim
8	Copay	Total Iowa Medicaid copayment on claim
9	Mcaid Paid Amt	Total amount paid by Medicaid on claim
10	Med Rcd Num	Medical record number OR patient account number
11	Line	Line number
12	Svc-Date	Date of service on line
13	Proc Mods	CPT or HCPCS code and modifier billed
14	Units	Number of units billed
15	Mcare Paid Amt	Medicare paid amount on line item



	Field Name	Field Description
16	Mcare Apprd	Medicare approved amount on line item
17	Deductible	Medicare deductible amount on line item
18	Coins. Amt.	Medicare coinsurance amount on line item
19	Copay	Iowa Medicaid copayment on line item
20	Mcaid Paid Amt	Total amount paid by Medicaid on line
21	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> <li>A Anesthesia</li> <li>B Billed charge</li> <li>C Percentage of charges</li> <li>D Inpatient per diem rate</li> <li>E EAC priced plus dispense fee</li> <li>F Fee schedule</li> <li>G FMAC priced plus dispense fee</li> <li>H Encounter rate</li> <li>I Prior authorization rate</li> <li>K Denied</li> <li>L Maximum suspend ceiling</li> <li>M Manually priced</li> <li>N Provider charge rate</li> <li>O Professional component</li> <li>P Group therapy</li> <li>Q EPSDT total over 17</li> <li>R EPSDT total under 18</li> <li>S EPSDT partial over 17</li> <li>SP Not yet priced</li> <li>T EPSDT partial under 18</li> <li>U Gynecology fee</li> <li>V Obstetrics fee</li> <li>W Child fee</li> <li>X Medicare or coinsurance deductibles</li> <li>Y Immunization replacement</li> <li>Z Batch bill APG</li> <li>0 APG</li> <li>1 No payment APG</li> <li>3 HMO/PHP rate</li> <li>4 System parameter rate</li> <li>5 Statewide per diem</li> <li>6 DRG auth or new</li> <li>7 Inlier/outlier adjust</li> <li>8 DRG ADR inlier</li> <li>9 DRG ADR</li> </ul>



Field Name		Field Description
22	EOB	Explanation of benefits denial reason code. A full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.

#### 4. Outpatient Crossover Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described

R.A. NO.: A  
00000000

WARRANT NUMBER: B  
00000000

C

<span style="border: 1px solid red; padding: 2px;">D</span> PROVIDER NAME
PROVIDER ADDRESS
PO BOX XXX
ANYTOWN IA 00000-0000

---- NEWSLETTER UPDATE ----

\*\*\*\*\*IMPORTANT IME INFORMATION\*\*\*\*\*

E

IMPORTANT INFORMATION AND REMINDERS FROM IME WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IMEPROVIDERSERVICES@DHS.STATE.IA.US

IAMC8000-R001 (CP-O-12)  
AS OF XX/XX/XX

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
R E M I T T A N C E A D V I C E

RUN DATE **F**  
XX/XX/XX

TO: **C** PROVIDER NAME R.A. NO.: **A** 0000000 WARR NO.: 0000000 **B** DATE PAID: **G** XX/XX/XX PROV. NUMBER: **H** 1234567890 PAGE: **I** 1

\* PATIENT NME \* RECIPIENT DATES OF SERVICE MEDICARE DEDUCT- COINS. MCAID MEDICAL  
LAST FI MI IDENT NUM TRANS-CONTROL-NUMBER FIRST LAST PAID AMT IBLE AMT. PAID AMT RECORD NO. EOB EOB

\* \* \* CLAIM TYPE: OUTPATIENT CROSSOVER \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9	10
LAST F	1111111A	0-00000-00-000-0000-00	XX/XX/XX XX/XX/XX	1000.00	00.00	50.00	50.00	XXXXXXXXXXLF	
DOE J	1111111B	3-00000-00-000-0000-01	XX/XX/XX XX/XX/XX	2000.00	250.00	25.00	275.00	XXXXXXXXXXDJ	

**Q** **2** CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... **R** 3000.00 **S** 250.00 **T** 75.00 **X** 325.00

TO: C PROVIDER NAME DDS R.A. NO.: A 00000000 WARR NO.: B 00000000 DATE PAID: G MM/DD/YY PROV. NUMBER: H 0000000000 PAGE: I 2

REMITTANCE TOTALS			
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">J</span> 0 -----	<span style="border: 1px solid red; padding: 2px;">K</span> 325.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
PENDEED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">L</span> 0 -----	0.00
AMOUNT OF EFT DEPOSIT:	-----		<span style="border: 1px solid red; padding: 2px;">M</span> 325.00

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

<span style="border: 1px solid red; padding: 2px;">N</span> <span style="border: 1px solid red; padding: 2px;">O</span> 000	<span style="border: 1px solid red; padding: 2px;">P</span> EXPLANATION (EOB) OF DENIAL CODE	<span style="border: 1px solid red; padding: 2px;">1</span>
---	--	---



	Field Name	Field Description
Q	Number of Claims	Total number of claims within same claim type or status
R	Medicare Paid Amt	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
X	Mcaid Paid Amt	Total amount Medicaid paid within same claim type or status

1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or patient account number
10	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



## 5. Capitation Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status

R.A. NO.: A  
00000000

WARRANT NUMBER: B  
00000000

C

PROVIDER NAME	D
PROVIDER ADDRESS	
PO BOX XXX	
ANYTOWN	IA 00000-0000

---- NEWSLETTER UPDATE ----

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AS OF XX/XX/XX

TO: C PROVIDER NAME R.A. NO.: A 0000000 WARR NO.: B 0000000 DATE PAID: G XX/XX/XX PROV. NUMBER: H 1234567890 PAGE: I 1

\*\*\*\* PATIENT NAME \*\*\*\* RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /  
LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

\* \* \* CLAIM TYPE: CAPITATION \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
DOE JOHN	1234567A	4-00000-00-000-0000-01	2.00	0.00	2.00	0.00		000 000
	01	XX/XX/XX W4001	2.00		2.00	0.00	1555555555	4 000 000
DOE JANE	1597482D	4-00000-00-000-0000-02	2.00	0.00	2.00	0.00	1555555555	4 000 000
	01	XX/XX/XX W4001	2.00		2.00	0.00	1555555555	4 000 000

Q 2 CLAIMS - THIS TREATING PROVIDER. TOTALS... R 4.00 S 0.00 T 4.00 X 0.00

TO: **C** PROVIDER NAME DDS R.A. NO.: **A** 00000000 WARR NO.: **B** 00000000 DATE PAID: **G** MM/DD/YY PROV. NUMBER: **H** 0000000000 PAGE: **I** 2

REMITTANCE TOTALS		<b>J</b>		<b>K</b>		<b>L</b>	
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	-----	40.00		40.00	
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00		0.00	
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00		0.00	
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	40.00 -----		0.00		0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00		0.00	
AMOUNT OF EFT DEPOSIT:	-----					40.00	<b>M</b>

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

<b>N</b>	<b>O</b>	000 EXPLANATION (EOB) OF DENIAL CODE	<b>P</b>
			1



	Field Name	Field Description
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total copayment on claim
8	Med Rcd Num	Account number assigned by the provider
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on line
15	Paid by Mcaid	Amount paid by Medicaid on line
16	Copay Amt.	Copayment amount on line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number



Field Name		Field Description
18	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> <li>A Anesthesia</li> <li>B Billed charge</li> <li>C Percentage of charges</li> <li>D Inpatient per diem rate</li> <li>E EAC priced plus dispense fee</li> <li>F Fee schedule</li> <li>G FMAC priced plus dispense fee</li> <li>H Encounter rate</li> <li>I Prior authorization rate</li> <li>K Denied</li> <li>L Maximum suspend ceiling</li> <li>M Manually priced</li> <li>N Provider charge rate</li> <li>O Professional component</li> <li>P Group therapy</li> <li>Q EPSDT total over 17</li> <li>R EPSDT total under 18</li> <li>S EPSDT partial over 17</li> <li>SP Not yet priced</li> <li>T EPSDT partial under 18</li> <li>U Gynecology fee</li> <li>V Obstetrics fee</li> <li>W Child fee</li> <li>X Medicare or coinsurance deductibles</li> <li>Y Immunization replacement</li> <li>Z Batch bill APG</li> <li>0 APG</li> <li>1 No payment APG</li> <li>3 HMO/PHP rate</li> <li>4 System parameter rate</li> <li>5 Statewide per diem</li> <li>6 DRG auth or new</li> <li>7 Inlier/outlier adjust</li> <li>8 DRG ADR inlier</li> <li>9 DRG ADR</li> </ul>
19	EOB	Explanation of benefits denial reason code