State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
*Governor*

WILLIAM WALDMAN
*Commissioner*

**MEDICAID COMMUNICATION NO.** 97-7 **DATE:** April 24, 1997

**TO:** County Welfare Agency Directors

**SUBJECT:** Completion of Medically Needy Claim Transmittal Form (FD-311)

This is to advise you that the Unisys system modifications to the Medicaid Management Information System (MMIS) have now been completed. This will enable providers to be paid directly for claims requiring the attachment of the Medically Needy Claim Transmittal Form (FD-311).

The completed FD-311 form is to be mailed by the county welfare agency to the appropriate provider who will enter their provider number, attach the appropriate claim form, and forward the package to Unisys for processing.

Unisys claim reviewers will screen the FD-311 and the attached claim form for correct completion when received from the provider. Errors found on the FD-311 will be returned to the county welfare agency for correction.

**Please note:** When the FD-311 is returned to the CWA, the claim form will remain attached. CWA staff are to make corrections to the FD-311 **only.** Unisys will identify the errors and instruct you **where** to send the corrected FD-311 and attached claim form.

Attached are instructions for the proper completion of the Claim Transmittal Form (FD-311) and a sample of a correctly completed FD-311.

This Communication is to be brought to the attention of all CWA staff involved in the completion of Claim Transmittal Form (FD-311). Please direct any questions that you may have to the field service staff assigned to your county.

Sincerely,

Karen I. Squarreii
Acting Director

KIS:G
Attachments
c: Len Fishman, Commissioner
Susan C. Reinhard, Ph.D., Deputy Commissioner
Department of Health and Senior Services

Karen Highsmith, Director
Division of Family Development

Michele Guhl, Acting Director
Division of Youth and Family Services

# Instructions for Completion of Medically Needy Claim Transmittal (FD-311)

Completing form FD-311 according to the following instructions will expedite claim processing and minimize the need for Unisys to return the form to the CWA for corrections.

## 1. RECIPIENT INFORMATION

Enter the recipient's ten digit Medicaid ID number plus the two digit person number. Enter the beneficiary's full name and address.

## 2. PROVIDER INFORMATION

Leave the space for the provider number blank. The provider will fill in this number and attach the claim form after the provider receives the form from the CWA. Enter the provider's full name and address.

## 3. TYPE OF SERVICE

List a brief description of each service rendered. Duplicate services are listed separately. Be sure that the service is covered under the beneficiary's eligibility group service package.

## 4. DATE OF SERVICE

List the date of service. Do not enter more than one date in each block. **Do not** span dates, i.e., 12/2/96 - 12/3/96.

## 5. CHARGE

List the provider's full charge as shown on the billing statement with no deductions taken for any payment.

## 6. PAYMENT FROM OTHER SOURCE

The amount to be entered is the total of all third party and client payments made to the provider. Third party payments include those made by a health insurance carrier, auto insurance company, workman's compensation, or any other responsible third party. Also include any adjusted (write off) or Medicare allowance amounts.

## 7. CLIENT OBLIGATION

If there is a split-claim, enter the portion of the charge which was used to meet the spend-down. This is the beneficiary's obligation which he/she must pay to the provider. If this charge was not used to meet the spend-down, enter zero (0).

## 8. TOTAL FROM OTHER SOURCES

Simply add the amount in "PAYMENT FROM OTHER SOURCE" to the amount in "CLIENT OBLIGATION." This total is entered in the "TOTAL FROM OTHER SOURCES" space. If the total is zero (0), enter zero (0).

**9.** "X" out all lines not used.

## 10. NUMBER OF ITEMS

Enter the total number of line items listed.

## 11. SIGNATURE

Enter the signature and title of the CWA worker and the name and address of the agency. This will make it easier for Unisys to return the form for correction, if needed.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

# MEDICALLY NEEDY CLAIM TRANSMITTAL

(Sample)

**RECIPIENT INFORMATION** (1)

0325000000-01
HSP (Medicaid) CASE NO.

John Smith
NAME

8 Main St., Anytown, NJ 08000
ADDRESS

**PROVIDER INFORMATION** (2)

PROVIDER NO.

S. W. Jones, M.D.
PROVIDER NAME

Family Clinic Rt. 0, Anytown, NJ 08000
PROVIDER ADDRESS

| | TYPE OF SERVICE (3) | DATE OF SERVICE (4) | CHARGE (5) | PAYMENT FROM OTHER SOURCE (6) | CLIENT OBLIGATION (7) | TOTAL FROM OTHER SOURCES (8) |
|---|---|---|---|---|---|---|
| 1. | Office Visit | 12/2/96 | 50.00 | 0 | 10.00 | 10.00 |
| 2. | Injection | 12/2/96 | 15.00 | 0 | 0 | 0 |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | | | | | | |
| 10. | | | (9) | | | |
| 11. | | | | | | |
| 12. | | | | | | |
| 13. | | | | | | |
| 14. | | | | | | |
| 15. | | | | | | |

**Provider Instructions and Information:**

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS 2 (10)

SIGNATURE Sally Doe, IMT (11
Authorized Representative

Burlington CBSS 795 Woodlane Rd., Mt. Holly, NJ 08000

FD-311 (5/86)