INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Financial Transactions and Remittance Advice

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of Aug. 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: April 6, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of Sept. 1, 2017 Published: Dec. 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of Oct. 1, 2018 Published: Jan. 15, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of Nov. 1, 2019 Published: Feb. 27, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of Nov. 1, 2020 Published: March 19, 2021	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of Dec. 1, 2021 Published: Aug. 5, 2022	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of Aug. 1, 2024 Published: March 13, 2025	Scheduled update: • Edited text as needed for clarity • Updated Gainwell addresses • Updated initial note • Updated the *Requesting Paper RA Copy* section • Updated the *Receiving RA Information Through 835 Electronic Transaction* section • Updated the initial note in the *Viewing Payment History and RAs via the IHCP Portal* section • Updated *Table 1 – Provider Remittance Advice Fields* • Updated the *Claim Adjustment Reason Codes* section • Deleted the *Financial ARCs* section and merged the information in other sections	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated web location of remittance advice remark codes in the *Adjustment Remark Codes* section • Updated *Table 4 – RA Summary Page Fields* • Updated *Figure 16 – RA Medical Education Cost Expenditures and Medical Education Cost Adjustments* and *Figure 24 – RA Summary Page (Part 1 of 2)* • Updated the *Accounts Receivable and Other Provider-Level Adjustments and Financial Transactions* section • Updated *Figure 25 – Transfer Letter*, *Figure 26 – Demand Letter* and *Figure 27 – Payment and Recoupment Agreement* • Removed outdated information from the *FQHC/RHC Wraparound Payment for Professional and Dental Encounter Claims* section • Updated the *EFT Rejections* section	

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Financial Transactions and Remittance Advice

*Note: The procedures in this module pertain to services provided within the **fee-for-service** (FFS) delivery system, with the following exceptions:*

- *Pharmacy services reimbursed through the FFS pharmacy benefit manager, Optum Rx*
- *Nonemergency medical transportation (NEMT) services reimbursed though the FFS transportation broker, Verida*

*Questions about financial transactions related to services provided within the **managed care** delivery system – including the Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Indiana PathWays for Aging (PathWays) programs – should be directed to the member's managed care entity (MCE).*

Contact information for Optum Rx, Verida and each MCE is available in the IHCP Quick Reference Guide at in.gov/medicaid/providers.

For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.

Introduction

The most significant tool the Indiana Health Coverage Programs (IHCP) provider has to monitor participation in the program is the weekly remittance advice (RA). The RA statement provides information about claim processing and financial activity. To assist providers in using the RA, this module provides examples of each RA section, along with a detailed description of each field.

In addition to claim adjudication, a variety of transactions unrelated to a particular claim affects providers. These transactions are referred to as *non-claim-specific* financial transactions. This module outlines the different transactions, how each transaction is handled, and where the transaction appears on the weekly RA. This module also includes information about the following topics:

- Electronic funds transfer (EFT)
- Stop payments and reissuance of IHCP checks
- Voids of IHCP checks
- Accounts receivable (A/R)
- Internal Revenue Service (IRS) reporting requirements

Provider Remittance Advice

The IHCP financial cycle runs every Friday. Payments are calculated based on paid claims, less payments for outstanding accounts receivable and liens. Check payments are dated for the Wednesday following the financial cycle. EFT payments are deposited to the provider's designated bank account each Wednesday following the financial cycle.

RA statements about the status of processed claims and payment details are available to providers via the IHCP secure website, the IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers. The IHCP Portal posts the weekly RA online after the financial cycle processes. Providers are encouraged to access the portal each week to review and download their latest RA. RAs from February 21, 2017, to the current RA are stored on the portal and available for review at any time. See the *Viewing Payment History and RAs via the IHCP Portal* section for instructions.

Requesting Paper RA Copy

Providers can request to receive a printed copy of an RA by mail – for example, in situations where the provider is no longer actively enrolled in the IHCP and therefore unable to access RAs via the IHCP Portal. Requests for printed RAs must be submitted, along with the appropriate payment, to the Written Correspondence Unit, either on the provider's letterhead or using the *Indiana Health Coverage Programs Written Inquiry* form, available on the *Forms* page at in.gov/medicaid/providers. Multiple RAs may be included in the same request and paid for with the same check.

The cost for a paper RA is $0.15 a page. The provider must first determine the total number of pages, which can be done by calling Customer Service (800-457-4584), checking the IHCP Portal or submitting a written request (by mail or using IHCP Portal secure correspondence). The provider then sends a check for the full amount, made out to **Gainwell Technologies**, along with their written request for the paper RAs, to the following address:

Remittance Advice Copies
Gainwell – Written Correspondence
PO Box 50442
Indianapolis, IN 46250-0418

> *Note: Providers can download their RAs free of charge via the IHCP Portal. See the Viewing Payment History and RAs via the IHCP Portal section for download instructions and help desk information. The IHCP Portal Help Desk is not a contact to request RA copies; it should only be used to determine if there are issues with connectivity or linkage to the IHCP Portal.*

Receiving RA Information Through 835 Electronic Transaction

To receive RA information through the 835 Health Care Claim Payment/Advice electronic transaction, also known as an electronic remittance advice (ERA), providers are required to complete a trading partner profile and agreement. For instructions, see the *Trading Partner Registration Procedure* page at in.gov/medicaid/providers.

After establishing a trading partner ID, providers can sign up to receive ERA/835 transactions by logging in to the IHCP Portal and going to **My Home** > **Provider Maintenance** > **ERA Changes**.

For detailed information about the 835 transaction, the *835 Implementation Guide* is available by subscription through the X12 website at X12.org/products. In addition, an IHCP-specific companion guide for the 835 transaction is available on the *IHCP Companion Guides* page at in.gov/medicaid/providers. See the *Electronic Data Interchange* module for information.

Viewing Payment History and RAs via the IHCP Portal

> *Note: See the Provider Healthcare Portal module for general information about registering for and using the IHCP Portal. For technical assistance with the portal, such as connectivity issues or problems downloading or viewing RAs, contact the IHCP Portal Help Desk at 800-457-4584; press option 3 and then option 2.*

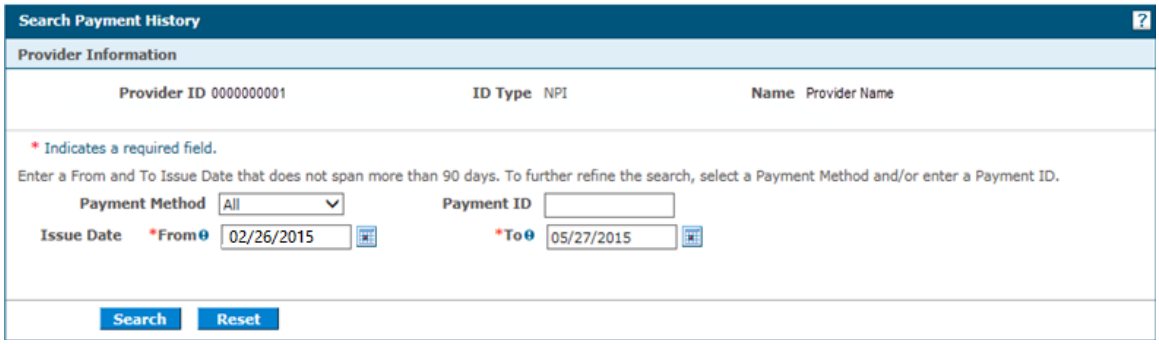
Providers (and their delegates with appropriate permissions) can log in to the IHCP Portal to view electronic funds transfer (EFT), check-payment and zero-pay-payment records for claims, as well as to view and download the associated remittance advice (RA).

RAs on the IHCP Portal show all FFS, nonpharmacy activity involved with a given week's payment. You can search through an RA to see if a specific claim has been paid, suspended or denied. Adobe Acrobat Reader is required to open and view RA documents in the portal.

Follow these steps to search payment history, view payment details, and view and download PDF copies of RAs on the portal:

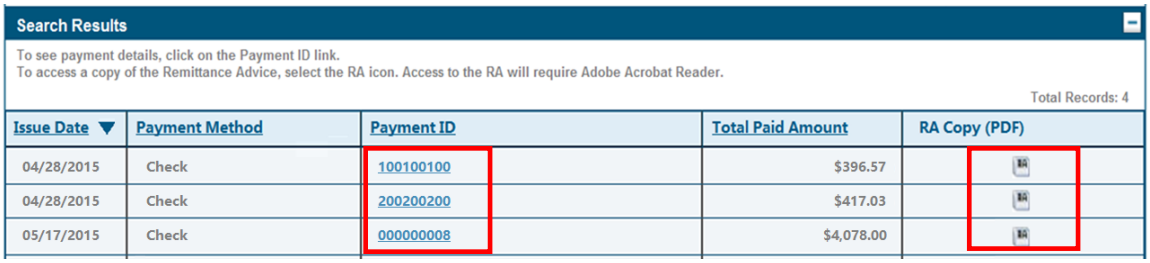
1. From the IHCP Portal menu bar, select **Claims > Search Payment History**.
2. In the *Search Payment History* panel, add or adjust the search criteria as desired:
   - The Issue Date fields automatically populate with the date of the search (today) in the To field and 90 days prior to today's date in the From field. You can narrow the date range to show fewer search results.
   - You can also narrow search results by payment method and/or payment ID.
3. After you have entered all the desired search parameters, click **Search**.

Figure 1 – Search Payment History



4. View search results to locate the desired payment:
   - Any claims that fall within the desired search parameters are displayed in the *Search Results* panel.
   - You can sort search results by clicking any of the underlined column names. The arrow next to the column name indicates whether the results are displayed in ascending or descending order. The example in the following figure shows the search results sorted in descending order by issue date.

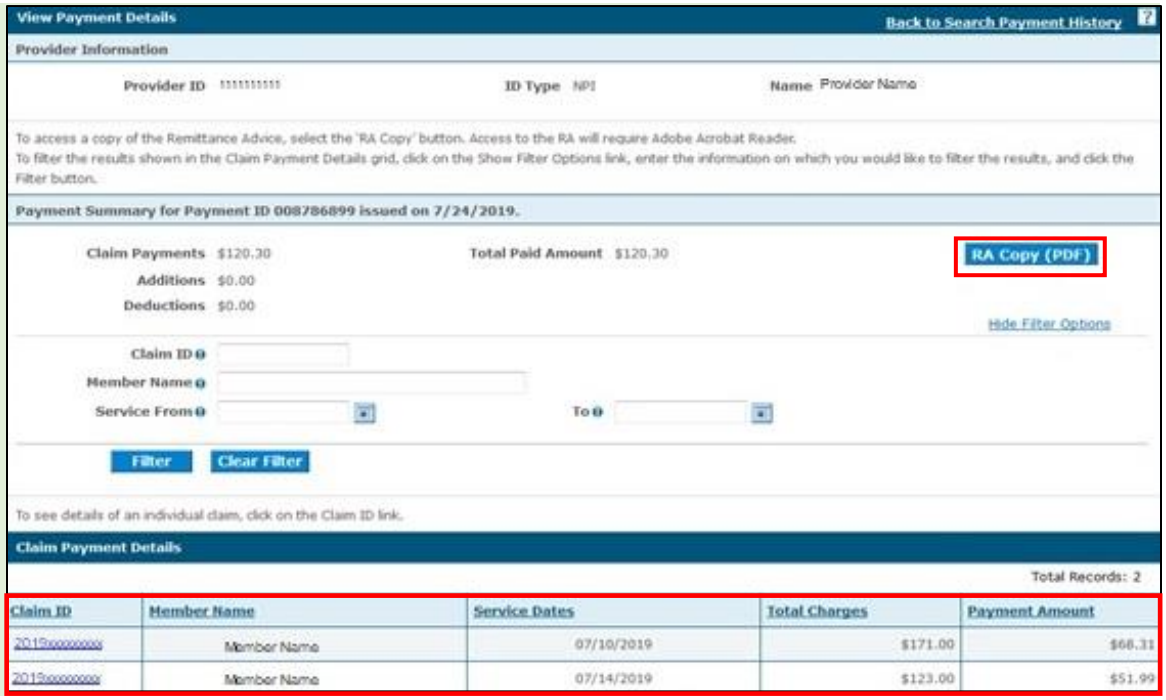
Figure 2 – Payment History Search Results



> *Note: The search results include an option to access the RA associated with each payment by clicking the icon in the **RA Copy (PDF)** column. The same RAs can also be accessed from the View Payment Details page for each payment, as described step 7.*

5. To view details about a specific payment, click the corresponding link for that payment in the **Payment ID** column to open the *View Payment Details* page.

Figure 3 – View Payment Details (with Payment Summary Filter Options)



6. View information about claims associated with the selected payment, as follows:
   - Scroll through the list in the *Claim Payment Details* panel to view the Claim ID, member name, service dates, total charges and payment amount for all claims associated with the payment.
   - If desired, use filter options in the *Payment Summary…* section to narrow the list to a specific claim number, member name or service date range.
   - Click the Claim ID link for any claim in the list to view the associated claim.
7. To view (and optionally download) the RA for the payment, click **RA Copy (PDF)**.

Remittance Advice Overview

RAs provide information about in-process claims, suspended claims and adjudicated claims that are paid, denied or adjusted. The RA reports claim activity only for each specific week. The RA also provides information about other processed financial transactions.

The RA is an important provider payment and claim-tracking device. Providers should reconcile claim transactions as soon as possible after receiving the RA statement. RA pages outline claim data in the following two ways:

- Header (claim level) information that applies to the entire claim
- Detail (service-line level) information that refers to a single line

Each RA section, such as *Claims Paid* or *Claims in Process*, totals the information after the last claim entry in that section. In addition, the RA *Summary* page includes data about individual sections. Information on the RA is standardized, as much as possible, for all claim types.

This document describes RAs from a general perspective and provides RA field definitions. For specific questions about an RA statement, refer to the explanation of benefits (EOB) and adjustment reason code (ARC) descriptions at the end of the RA.

> *Note: The unique number assigned to each claim, referred to as the **Claim ID** on the IHCP Portal, is identified on the RA as **ICN** (internal control number).*

Remittance Advice Section Descriptions

The RA includes the following sections, as applicable:

- *Claims Paid*: This RA section shows claims with a paid status, including claims paid at zero. (An example of a zero-paid claim is a claim for a member with other insurance, when the other insurance paid an amount equal to or greater than the IHCP allowable amount.) Claims are sorted by claim type: professional, dental, inpatient, outpatient, home health, long-term care, Medicare crossover professional and Medicare crossover institutional.
- *Claims Denied*: This RA section shows the same basic information as for paid claims. The IHCP denied payment for these claims.
- *Claims in Process*: This RA section lists claims in the processing cycle that have not been finalized. This section includes claims that have attachments, claims that are past the filing limit, claims that require manual pricing, claims for voids and replacements that have not been finalized, and suspended claims. **The IHCP has not denied these claims.** The EOB, ARC and adjustment remarks provided with the in-process claim provide information as to why the claim has not yet been processed. Claims reflected as in process are resolved as paid, denied or adjusted on subsequent RAs. Providers must monitor claims in process to final resolution. Claims in suspense appear in the RA only for the week in which they are **first** suspended.

  Note: Each claim in process lists the EOB message that corresponds to the reason it has been suspended.

- *Claim Adjustments*: This RA section lists adjusted claims, also known as *voids and replacements*. Each adjusted claim shows two header lines. The first header line is for the original claim, and the second header line is for the replacement claim. If a previously adjusted claim requires additional adjustment, the last ICN/Claim ID assigned becomes the original claim to become adjusted.
- *Payment Hold:* This RA section lists all ICNs/Claim IDs whose payment is on hold.
- *Medical Education Cost Expenditures/Adjustments:* This RA section lists all medical education payments made for managed care claims and claim adjustments.
- *Wrap Payment Expenditures/Adjustments:* This RA section lists the federally qualified health center (FQHC) and rural health clinic (RHC) wraparound (supplemental) payments for medical and dental encounter claims and claim adjustments for managed care members. The wrapround payment is the difference between the total amount paid by the managed care entity (MCE) and other insurance carriers and the FQHC/RHC encounter rate.
- *Financial Transactions*: This RA section lists the provider-level adjustments, which includes non-claim-specific payouts, refunds and A/R transactions. The IHCP uses a transaction number to uniquely identify each financial transaction. If a financial transaction is associated with a cash receipt, then the cash control number (CCN) displays. All financial transactions identify an adjustment to net payment, either positive or negative. Examples of miscellaneous financial transactions tabulated in this RA section include the following:
  - Refunds made by a provider that exceed the original claim payment. Core Medicaid Management Information System (*Core*MMIS) generates a payout to return the over-refunded amount to the provider.
  - Adjusted claim resulting in a negative balance, which creates an A/R.
  - Amounts scheduled for recouping. The A/R offset section tracks the repayment of the amount to be recouped.
- *EOB Code Descriptions*: This RA section lists EOB codes applied to submitted claims, along with the respective code narrative. These codes and corresponding narratives describe the reasons submitted claims are adjusted, suspended, or denied or did not pay in full. The order of the description list is numeric for EOB codes 0000 to 9999.

- *Adjustment Reason Code Descriptions*: This RA section lists the ARCs and their respective code narratives that reflect the adjustments in payment, between the billed amount and the allowed or payment amounts, applied to submitted claims at the claim level or the service-line level. The order of these codes and corresponding narratives is numeric, then alphanumeric.
- *Service Code Descriptions:* This RA section lists all procedure and/or revenue codes that appear on the RA and provides corresponding descriptions.
- *Remark Code Descriptions:* This RA section lists all remark codes that appear on the RA and provides corresponding descriptions.
- *Summary*: This page reflects data from the entire RA series. This page summarizes all claim and financial activity (provider-level adjustments) for each weekly cycle and reports year-to-date totals. In addition, the report provides information about lien payments made to external lien holders during the current payment or financial cycle and year-to-date. The *Summary* page also reports capitation payments (for managed care entities only).

The 835 transaction reports claims by ICN/Claim ID. For a specific provider, all the claims are sorted by ICN/Claim ID and reported together, followed by any provider-level adjustments.

Remittance Advice Claim Sorting Sequence

Claims are shown on the RA by type and according to the following priority sequence:

- *CMS-1500* claim form/IHCP Portal professional claim/837P transaction
  - Alphabetically by member name
  - Numerically by ICN/Claim ID
- *UB-04* claim form/IHCP Portal institutional claim/837I transaction
  - Alphabetically by member name
  - Numerically by ICN/Claim ID
- *ADA 2012* claim form/IHCP Portal dental claim/837D transaction
  - Alphabetically by member name
  - Numerically by ICN/Claim ID

Crossover claim data appears first on the RA and follows the priority sequence per claim type.

The 835 electronic transaction sorts claims in the following sequence:

- Trading partner identification
- Billing National Provider Identifier (NPI)
- ICN/Claim ID

Remittance Advice Field Definitions

Table 1 lists the RA fields in alphabetical order. Each field name is preceded by a number that corresponds to where the field appears in Figures 4 through 23. Where applicable, slight variations in field names (depending on the RA type or section in which the field appears) also appear in Column 1. Column 2 includes a description of the information contained within that field. Column 3 indicates in which RA section the field may appear and, where applicable, on which type of RA. In addition, for some fields, Column 4 of the table includes a description of how the information appears on the electronic 835 transaction.

> *Note: Not all fields appear on each section of the RA. Many fields are specific to the claim type being billed.*

Table 1 – Provider Remittance Advice Fields

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
1 ADDITIONAL PAYMENT	Additional amount owed to a billing provider as the result of a claim adjustment.	*Claim Adjustments, Medical Education Cost Adjustments*	
2 ADJUSTMENT ICN	Unique identifier (ICN/Claim ID) of the adjusted claim that resulted in the creation of an accounts receivable.	*Financial Transactions – Accounts Receivable*	
3 ADMIT DATE ADMIT DT	Date the member was admitted to a hospital.	*Claim Adjustments, Claims Paid, Claims Denied, Claims in Process* (Inpatient and Medicare Crossover Institutional)	
4 AMOUNT HELD	The amount payable for a transaction being held from payment due to a payment hold request.	*Payment Hold*	
5 AMOUNT RECOUPED IN CURRENT CYCLE	Total amount recouped during the current financial cycle.	*Financial Transactions – Accounts Receivable*	PLB04
6 A/R NUMBER	Unique number assigned to each account receivable setup in the financial system.	*Financial Transactions – Accounts Receivable*	PLB03-2
7 ARC CODE / DESCRIPTION	A list of all the claim adjustment reason codes (ARCs) that appear on the RA, and the narrative description for each code.	*ARC Code Descriptions*	
8 ARCS	Adjustment reason codes (ARCs) that apply to the claim. Each line in this field can contain a maximum of 20 ARCs.The line labeled 000 lists ARCs related to the claim header. Lines labeled 001–999 list ARCs related to each claim detail. ARCs may indicate that the claim paid as billed or describe the reason the claim was suspended, denied or adjusted. *Note: Descriptions for each ARC reported appear on a separate page of the RA.*	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process*	• CAS claim level if the line number is 0 • CAS service level if the line number is 1 through 450

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
9 AREA OF ORAL CAV	Quadrant of the mouth where dental services were performed.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Dental)	
10 ALLOWED AMOUNT ALLOWED AMT *[Header level]*	Computed dollar amount allowable by Medicaid for the claim. A header allowed amount represents only amounts applied to the header portion of the claim.	*Claim Adjustments,* *Claims Paid*	
11 ALLOWED AMT *[Detail level]*	Computed dollar amount allowable by Medicaid for each detail item billed.	*Claim Adjustments,* *Claims Paid*	AMT02
12 ALLOWED AMT *[Medicare]*	Amount that was allowed by Medicare for the services.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Medicare Crossover Professional Service)	
13 ALLW UNITS	Units of service allowed for the detail.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	SVC05
14 BALANCE	Amount outstanding for the accounts receivable.	*Financial Transactions – Accounts Receivable*	PLB segment • If the A/R was created in the current financial cycle, the PLB segment contains the amount of A/R or the amount recouped in this cycle. • If the A/R was created in a previous financial cycle, the PLB segment contains the balance remaining on the A/R or the amount recouped in this cycle.

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
15 BILLED BILLED AMT BILLED AMOUNT *[Header level]*	Amount requested by the provider for the claim. The header billed amount is arrived at by adding the detail billed amounts on all the detail lines. *Note: On medical education cost and FQHC/RHC wrap payment sections, this field lists header-level billed amounts for each applicable managed care claim.*	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process,* *Dental Wrap Payment Expenditures/Adjustments,* *Medical Education Cost Expenditures/Adjustments,* *Wrap Payment Expenditures/Adjustments*	CLP03
16 BILLED AMT BILLED AMOUNT *[Detail level]*	Amount requested by the provider for the item billed on each detail line.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	SVC02
17 BLOOD DEDUCT *[Medicare]*	Amount of money paid toward the blood deductible on a Medicare Crossover claim.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Medicare Crossover Institutional)	
18 C DAYS	Number of days the member was in the hospital.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Inpatient)	
19 CO-INS *[Medicare]*	Amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
20 CO-INS CB	The coinsurance cutback amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	*Claim Adjustments,* *Claims Paid*	
21 COND CODE	Condition code identifies conditions relating to this bill that may affect payer processing.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Long Term Care)	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
22 COPAY AMT *[Detail level]*	Amount of member responsibility on a claim detail that is to be collected by the provider at the time the service is rendered.	*Claim Adjustments, Claims Paid*	
23 COPAY AMT *[Header level]*	Amount of member responsibility on a claim that is to be collected by the provider at the time the service is rendered. A header copay amount represents only amounts applied to the header portion of the claim.	*Claim Adjustments, Claims Paid*	
24 COPAY AMT *[Medicare]*	Amount of member responsibility on a Medicare claim that is to be collected by the provider at the time the service is rendered. Medicare copay may be paid by Medicaid.	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
25 DAYS	Number of days the member was in the facility.	*Claim Adjustments, Claims Denied, Claims Paid* (Long Term Care and Medicare Crossover Institutional)	
26 DEDUCT *[Medicare]*	Amount that the member is responsible for paying. This dollar amount will crossover and be paid by Medicaid.	*Claim Adjustments, Claims Denied, Claims Paid* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
27 DRG CD	Diagnosis-related group (DRG) is the system used to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, developed for Medicare as part of the prospective payment system. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or comorbidities.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Inpatient)	CLP11
28 EOBS	Explanation of benefits (EOB) codes that apply to the claim. Each line in this field can contain a maximum of 20 four-digit EOB codes. The line labeled 000 lists EOBs related to the claim header. Lines labeled 001–999 list EOBs related to each claim detail. EOBs may indicate that the claim paid as billed or describe the reason the claim was suspended, denied or adjusted. *Note: Descriptions for each EOB reported appear on a separate page of the RA.*	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	Not applicable EOB codes are IHCP-specific and cannot be written to the 835 transaction. Only national standard X12 835 ARC and remark codes are written to the 835 transaction.
29 EOB CODE/ DESCRIPTION	A list of all explanation of benefits (EOB) codes that appear on the RA, with a narrative description of each code. In addition to claim-related EOBs, this section also includes EOBs that correspond to reason codes returned in the *Financial Transactions* section.	*EOB Code Descriptions*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
30 FIN ARC	Adjustment reason codes (ARCs) that apply to the financial transaction.	*Financial Transactions*	PLB segment for provider-level adjustments
31 ICN	Internal control number (ICN), which uniquely identifies a claim. (On the IHCP Portal, this number is referred to as the *Claim ID*.)	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, *Claims in Process*, *Dental Wrap Payment Expenditures/Adjustments*, *Medical Education Cost Expenditures/Adjustments*, *Wrap Payment Expenditures/Adjustments*	CLP07
32 INPAT DED INPAT/OUTPAT DED	One time set annual cost to the member. Displays how much of the claim paid amount was cut back due to this specific deductible.	*Claim Adjustments*, *Claims Paid* (Inpatient and Medicare Crossover)	
33 MED ED AMT MEDICAL ED AMT	Amount of medical education cost paid for managed care claims during the current financial cycle.	*Medical Education Cost Expenditures/Adjustments*	
34 MEMBER NAME	Name of the member identified on the claim.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, *Claims in Process*, *Financial Transactions*, *Medical Education Cost Expenditures/Adjustments*	• Last name: NM103 • First name: NM104 • Middle initial: NM105
35 MEMBER NO.	Unique IHCP identifier of the member, referred to on the IHCP Portal as Member ID (also known as RID).	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, *Claims in Process*, *Dental Wrap Payment Expenditures/Adjustments*, *Financial Transactions*, *Medical Education Cost Expenditures/Adjustments*, *Wrap Payment Expenditures/Adjustments*	NM109 using qualifier code QC
36 MODIFIERS	Code used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, *Claims in Process*	SVC01-3, SVC01-4, SVC01-5 and SVC01-6
37 MRN	The unique medical record number (MRN) assigned by the provider. This number is usually used for filing or tracking purposes.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, *Claims in Process*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
38 NPI	Billing provider National Provider Identifier (NPI). If the NPI has not been reported to the IHCP, this field is blank. For atypical providers, this field is always blank.	All RA sections on all RA types	N104 N103 has a qualifier code of XX. If the NPI is not known, the F1 qualifier is in N103, and the billing provider federal taxpayer identification number (TIN) is in N104.
39 ORIGINAL AMOUNT	Setup amount of the accounts receivable.	*Financial Transactions – Accounts Receivable*	PLB segment • If the A/R was created in the *current* financial cycle, then the amount the A/R was created for or the amount recouped in this cycle will be written to the PLB segment. • If the A/R was created in a *previous* financial cycle, then the balance remaining on the A/R or the amount recouped in this cycle will be written to the PLB segment.
40 OTH INS AMOUNT OTH INS AMT	Dollar amount paid for the services by any source outside the IHCP, including Medicare.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	
41 OUTLIER AMT	Any reimbursable amount, in addition to the hospital DRG rate, for certain inpatient stays that exceed established cost thresholds associated with the hospital stay.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Inpatient)	
42 OUTPAT DED	One-time, set annual cost to the member. Displays how much of the claim paid amount was cut back due to this specific deductible.	*Claim Adjustments,* *Claims Paid* (Outpatient, Professional Service and Medicare Crossover Professional Service)	
43 OVER-PAYMENT TO BE WITHHELD	Additional amount owed by a billing provider as the result of a claim adjustment. If this amount cannot be recovered in the current cycle, an accounts receivable record is generated.	*Claim Adjustments,* *Medical Education Cost Adjustments*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
44 PAID AMOUNT PAID AMT *[Detail level]*	Amount that is payable for the claim detail.	*Claim Adjustments,* *Claims Paid*	SVC03
45 PAID AMOUNT PAID AMT *[Header level]*	Amount that is payable for the claim.	*Claim Adjustments,* *Claims Paid*	CLP04
46 PAID AMT *[Medicare]*	Amount that was paid under Medicare for the services/ hospitalization stay.	*Claim Adjustments,* *Claims Denied,* *Claims Paid* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
47 PATIENT NO. PATIENT NUMBER	The unique patient number assigned by the provider and submitted on the original claim. This number is usually used for internal tracking and control purposes.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process,* *Dental Wrap Payment Expenditures/Adjustments,* *Medical Education Cost Expenditures/Adjustments,* *Wrap Payment Expenditures/Adjustments*	CLP01
48 PATIENT LIAB	Monthly amount the member is responsible for paying toward fees such as the long-term care facility charge. This patient liability amount is subtracted from the allowed amount to arrive at the paid amount.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Home Health [for hospice claims], Long Term Care and Medicare Crossover Institutional)	CLP05
49 PAYEE ID	Provider ID of the entity receiving payment for goods or services. The Provider ID is a unique identification number issued by the IHCP.	All RA sections on all RA types	CLP05 • N104, if provider type = XX • REF02, if provider type = 1D
50 PAYMENT DATE	Date the checkwrite voucher is posted to the state accounting system. This is the Payment Date on the RAs and paper checks. It is not necessarily the release date of the EFT payments.	All RA sections on all RA types	BPR16

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
51 PAYMENT NUMBER	If a check was generated, the check number is listed. If the provider participates in EFT, this number is the control number of the EFT transaction.	All RA sections on all RA types	TRN02
52 PA NUMBER	Number assigned to a prior authorization (PA) request that is used for the adjudication of the claim detail.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	
53 PAYOUT AMOUNT	Amount of the expenditure issued to the payee.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	PLB04
54 PREVIOUS ICN	Unique identifier (ICN/Claim ID) of the previously submitted claim associated to the creation of the accounts receivable.	*Financial Transactions – Accounts Receivable*	
55 PROC CD	Procedure code for services rendered. Code that identifies a medical, dental or durable medical equipment (DME) service that is provided to the member.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	SVC01-2
56 PROVIDER NAME/ ADDRESS	Name and address of the provider billing for services.	All RA sections on all RA types	• Billing provider name: N102 using qualifier code PE • Billing provider address: N301 and N302 • Billing provider city: N401 • Billing provider state: N402 • Billing provider ZIP Code: N403
57 PSYCH CO-INS *[Medicare]*	Amount that the member should pay for psychiatry and is deducted from the allowed amount to arrive at the Medicare paid amount.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Medicare Crossover Professional Service)	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
58 REASON CODE	Identifies the reason for the account receivable setup. *Note: For each reason code returned in this field, the associated "AR EOB" code and description appears in EOB Descriptions section of the RA.*	*Financial Transactions – Accounts Receivable*	
59 REASON CODE	Identifies the reason for the non-claim-related expenditure payout. *Note: For each reason code returned in this field, the associated "EXP EOB" code and description appears in EOB Descriptions section of the RA.*	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
60 REASON CODE	Identifies the reason for the non-claim-related refund. *Note: For each reason code returned in this field, the associated "CASH EOB" code and description appears in EOB Descriptions section of the RA.*	*Financial Transactions – Non-Claim Specific Refunds From Payee*	
61 RECEIPT DATE	System-assigned date on which a cash receipt was established in the system, manually or systematically.	*Financial Transactions – Non-Claim Specific Refunds From Payee*	
62 RECOUPMENT AMOUNT TO DATE	Total cumulative amount recovered from the associated A/R.	*Financial Transactions – Accounts Receivable*	PLB04
63 REFUND AMOUNT	Amount received from the payee and returned to the payee during this financial cycle.	*Financial Transactions – Non-Claim Specific Refunds From Payee*	PLB04
64 REFUND AMOUNT APPLIED	Amount of a cash receipt received from the provider applied to a cash-related claim adjustment.	*Claim Adjustments*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
65 RELATED PROVIDER ID	The identifier for the provider related to the expenditure, who may not be the same as the payee. For Health Information Technology (HIT) expenditures, this individual will be the Electronic Health Record (EHR)-eligible provider. For other expenditures, this could be a different related provider.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
66 REMARK CODE / DESCRIPTION	A list of all remark codes that appear on the RA, and a narrative descriptions for each code.	*Remark Code Description*	
67 REMARKS	Codes reported in addition to ARCs, when needed to further clarify the reason for the adjustment. The line labeled 000 lists remark codes related to the claim header. Lines labeled 001–999 list remark codes related to each claim detail. Remarks report with ARCs only when they add information at the claim or service-line level. *Note: Descriptions for each remark code reported appear on a separate page of the RA.*	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process*	• If the line number is 0: ➢ MOA03, MOA04, MOA05, MOA06 and MOA07 for dental, outpatient, extended care facility, home health, professional services and Medicare Crossover Part B claims ➢ MIA05, MIA20, MIA21, MIA22 and MIA23 for inpatient and Medicare Crossover Part A claims • If the line number is 1 through 450: ➢ LQ02 using qualifier code HE for all claim types except drug and compound drug ➢ LQ02 using qualifier code RX for National Council for Prescription Drug Programs (NCPDP) codes on drug and compound drug claims.

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
68 RENDERING PROVIDER	NPI of the provider that rendered a particular service; for atypical providers, the unique IHCP Provider ID is used.	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process* (Dental, Professional Service, Outpatient and Medicare Crossover)	• Claim level: ➢ If the rendering provider is a healthcare provider, the XX qualifier is in NM108 and the NPI is in NM109. ➢ For atypical rendering providers, the MC qualifier is in NM108 and the IHCP Provider ID is in NM109. • Service level: ➢ If the rendering provider NPI has been reported to the IHCP, the XX qualifier is in REF01 and the NPI is in REF02. ➢ For atypical rendering providers, the 1D qualifier is in REF01 and the IHCP Provider ID is in REF02.
69 REV CD	Revenue codes that pertain to the services being billed on a *UB-04* claim form, IHCP Portal institutional claim or 837I transaction.	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process* (Home Health, Inpatient, Long Term Care, Outpatient and Medicare Crossover Institutional)	SVC04
70 SERVICE DATES FROM SER DT FROM *[Detail level]*	Earliest date of service for the claim detail.	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process*	DTM02 • DTM01=472 if the last date of service not present • DTM01=150 if the last date of service is present
71 SERVICE DATES TO SER DT TO *[Detail level]*	Last date of service for the claim detail.	*Claim Adjustments, Claims Denied, Claims Paid, Claims in Process*	DTM02, DTM01=151

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
72 SERVICE DATES FROM *[Header level]*	Earliest date of service for the claim.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process,* *Dental Wrap Payment Expenditures/Adjustments,* *Medical Education Cost Expenditures/Adjustments,* *Wrap Payment Expenditures/Adjustments*	DTM02 using qualifier code 232
73 SERVICE DATES TO *[Header level]*	Last date of service (or discharge date) for the claim.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process,* *Dental Wrap Payment Expenditures/Adjustments,* *Medical Education Cost Expenditures/Adjustments,* *Wrap Payment Expenditures/Adjustments*	DTM02 using qualifier code 233
74 SERVICE DATES FROM	The earliest date of service or admission date for the claim related to the expenditure.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
75 SERVICE DATES THRU	The latest date of service or discharge for the claim related to the expenditure.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
76 SERVICE DT SERVICE DATE	Date the service was rendered (for the detail or for the claim header).	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Dental and Outpatient)	DTM02 • DTM01=472 if the last date of service not present • DTM01=150 if it is present
77 SETUP DATE	System-assigned date the account receivable was established in the system, manually or systematically.	*Financial Transactions – Accounts Receivable*	
78 SPENDDOWN SPENDDOWN AMT *[Detail level]* *[Medicare]*	Obsolete.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Medicare Crossover Institutional and Medicare Crossover Professional)	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
79 SPENDDOWN SPENDDOWN AMOUNT SPENDDOWN AMT *[Header level]*	Amount applied (from the current RA) toward the member's Medicaid HCBS waiver liability. For members with a Medicaid waiver liability, a qualifying county worker assigns a monthly amount based on the member's income and other factors. The member must spend this amount on HCBS waiver expenses before Medicaid waiver benefits become available.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process*	
80 SURFACE	Code pertaining to the part of the tooth that was worked on.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Dental)	
81 SVC CODE / DESCRIPTION	List of all procedure codes and revenue codes represented on the RA, along with corresponding descriptions.	*Service Code Descriptions*	
82 TOOTH	Tooth number, from the dental claim form diagram, of the tooth receiving treatment.	*Claim Adjustments,* *Claims Denied,* *Claims Paid,* *Claims in Process* (Dental)	
83 TRANSACTION NUMBER	Number that uniquely identifies an expenditure transaction.	*Financial Transactions,* *Dental Wrap Payment Expenditures/Adjustments,* *Medical Education Cost Expenditures/Adjustments,* *Wrap Payment Expenditures/Adjustments*	PLB03-2
84 TRANSACTION TYPE	Indicates the source of the payment. Examples of transaction types are *expenditure*, or a specific claim type.	*Payment Hold*	
85 MCE ID	The identification number of the managed care entity for the FQHC or RHC claim	*Dental Wrap Payment Expenditures/Adjustments,* *Wrap Payment Expenditures/Adjustments*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
86 SUM OF ALL PAYORS	Displays the total amount paid by the MCE and other insurance carriers for each FQHC and RHC managed care encounter claim or adjustment.	*Dental Wrap Payment Expenditures/Adjustments, Wrap Payment Expenditures/Adjustments*	
87 WRAP AMOUNT	Displays the difference between the amount paid by the MCE and other insurers and the FQHC/RHC encounter rate for each FQHC and RHC managed care encounter claim or adjustment.	*Dental Wrap Payment Expenditures/Adjustments, Wrap Payment Expenditures/Adjustments*	
88 TOTAL WRAP PAYMENT SERVICES PAID TOTAL DENTAL WRAP PAYMENT SERVICES PAID	Displays the sum of wrap-around payment amounts for all paid FQHC and RHC managed care encounter claims.	*Dental Wrap Payment Expenditures, Wrap Payment Expenditures*	
89 TOTAL WRAP PAYMENT SERVICES ADJ TOTAL DENTAL WRAP PAYMENT SERVICES ADJ	Displays the sum of wrap-around payment amounts for all FQHC and RHC managed care encounter claim adjustments.	*Dental Wrap Payment Adjustments, Wrap Payment Adjustments*	
90 TOTAL MEDICAL EDUCATION COST PAID	Displays the sum of medical education costs paid for managed care claims during the current financial cycle	*Medical Education Cost Expenditures*	
91 TOTAL MEDICAL EDUCATION COST ADJ	Displays the sum of medical education cost amounts for managed care claim adjustments during the current financial cycle	*Medical Education Cost Adjustments*	

Explanation of Benefits Codes

Each RA provides four-digit EOB codes. These codes and the corresponding narratives indicate that the submitted claim paid as billed or describe the reason the claim suspended, was denied, was adjusted or did not pay in full. Because the claim can have edits and audits at both the header and detail levels, EOB codes are listed for header and detail information when applicable. The RA can list a maximum of 20 header-level EOBs, as well as a maximum of 20 EOBs for each detail line. Exceptions are suspended claims, which have a maximum of two EOBs per header and per detail. **EOBs for suspended claims are not denial codes, but list the reason the claim is being reviewed.**

Any applicable EOB codes are reported in the *Claim Adjustments*, *Claims Denied*, *Claims Paid* and *Claims in Process* sections of the RA. The EOB codes are listed immediately following the claim header and detail information, in a field marked **EOBS**. A three-digit label at the beginning of each line of EOB codes indicates which part of the claim the EOBs in that line pertain to, as follows:

- The line labeled 000 lists EOB codes related to the claim header.
- The line labeled 001 lists EOB codes related to the first claim detail.
- The line labeled 002 lists the EOB codes related to the second claim detail (and so on, for all subsequent details).

If no EOBs were posted for the header or for a particular detail of the claim, the corresponding EOB line does not appear on the RA.

Narrative descriptions of the EOB codes used on an RA appear in the *EOB Reason Code Descriptions* section of the RA (Figure 20). See the *Explanation of Benefits* page at in.gov/medicaid/providers to access a complete list of all EOBs. Table 2 provides some examples of EOB codes and narratives, and indicates what action is required of the provider in each case.

EOBs are considered local codes and are not transmitted in the 835 electronic transaction. Instead, *Health Insurance Portability and Accountability Act* (HIPAA)-compliant codes are transmitted in the 835 transaction.

Table 2 – Explanation of Benefits Code Examples

Code	Description	Provider Action Required
0000	Claim paid as billed.	No action required.
0001	Claim pended for examiner review.	No action required. Follow the progress of the claim on the RA or use the Interactive Voice Response (IVR) system.
0201	Billing LPI/NPI is missing; please provide and resubmit.	Resubmit claim with NPI or IHCP Provider ID (formerly known as the Legacy Provider Identifier [LPI]).
0203	Member I.D. number is missing; please provide and resubmit.	Resubmit claim with the IHCP member identification number (known as Member ID or RID).
2014	Personal resources collected does not agree with amount reported by county office. Liability amount deducted from your claim was based on the amount reported by the county office.	Verify the personal resource amount with the county office. When verified and corrected, return the adjustment request form. When adjustment is complete, resubmit the claim.
4033	The modifier used is not compatible with the procedure code billed. Please verify and resubmit.	See Current Procedural Terminology (CPT®[1]) code manual and resubmit claim with correct modifier.
6650	The number of services provided exceeds medical policy guidelines. This is a once-in-lifetime procedure.	For more information about benefit limits, including a list of all limits returned by the eligibility verification system (EVS), see the *Member Eligibility and Benefit Coverage* module.

[1] *CPT copyright 2024 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Claim Adjustment Reason Codes

Claim-specific ARCs are codes from an external national code set used with the *835 Implementation Guide* to report the associated dollars from the adjustment between the billed amount and the allowed or paid amount. These ARCs and the corresponding narratives describe the adjustment reason reported from each claim that adjudicated as denied or not paid in the full amount as billed.

Because the claim can process against edits and audits at both the claim (header) and service line (detail) levels, ARCs can be reported for the claim level and for each service line when applicable. The RA can list a maximum of 20 ARCs at the claim level and a maximum of 20 ARCs for each service line. Exceptions are suspended claims, which have a maximum of two ARCs per claim level and per service-line level. **ARCs for suspended claims are not denial codes, but rather the reason the claim is being reviewed.**

Any applicable claim-specific ARCs are listed in the *Claim Adjustments*, *Claims Denied*, *Claims Paid* and *Claims in Process* sections of the RA, immediately following the EOBs, in a field marked **ARCS**. A three-digit label at the beginning of each line of ARCs indicates which part of the claim the ARCs in that line pertain to, as follows:

- The line labeled 000 lists ARCs reported at the header level.
- Lines labeled 001, 002 and so on list ARCs reported for the first, second, and subsequent service details of the claim, respectively.

If no ARCs were posted for the header or for a particular service detail of the claim, the corresponding ARC line does not appear on the RA.

Narrative descriptions of the claim-specific ARCs used on an RA appear in the *Adjustment Reason Code Descriptions* section of the RA (see Figure 21). A complete list of claim-specific ARCs is available on the *Claim Adjustment Reason Codes* page at x12.org/codes.

> *Note: Financial ARCs are not part of the claim-specific ARC code set. Financial ARCs are codes associated with **nonclaim** financial transactions and activities that increase or decrease the net payment amount associated with the weekly RA. For information about Financial ARCs, see the Accounts Receivable and Other Provider-Level Adjustments and Financial Transactions section for more information.*

Table 3 provides some examples of claim-specific ARCs and narratives, as well as the associated EOB (see the *Explanation of Benefits Codes* section) and remark (see the *Adjustment Remark Codes* section), if applicable.

Table 3 – Claim Adjustment Reason Code Examples

ARC	ARC Description	Associated Remark	Associated EOB
206	National Provider Identifier missing.	N257 – Missing/incomplete/ invalid billing provider/ supplier primary identifier.	0201
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382 – Missing/incomplete/ invalid patient identifier.	0203
142	Monthly Medicaid patient liability amount.	No remark code available to further clarify.	2014
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519 – Invalid combination of HCPCS modifiers.	4033
149	Lifetime benefit maximum has been reached for this service/benefit category.	No remark code available to further clarify.	6650

Adjustment Remark Codes

Remark codes are codes from an external national code set used with the *835 Implementation Guide* to report the associated dollars from the adjustment between the billed and the allowed or paid amount. Each claim in the weekly RA includes adjustment remark codes when needed to clarify the reason for the adjustment to payment reported with a claim-related ARC. Remark codes are provided with the adjustment reason reported from each claim that adjudicated as denied or not paid in the full amount as billed.

Because the claim can process against edits and audits at the claim (header) and service line (detail) levels, remark codes can be reported for the claim level and for each service line when applicable. The RA can list a maximum of 20 remarks at the claim level and a maximum of 20 remarks for each service line. Exceptions are suspended claims, which have a maximum of two remarks per claim level and per service-line level. **Remark codes for suspended claims are not denial codes, but the reason the claim is being reviewed.**

Remark codes are listed in the *Claim Adjustments*, *Claims Denied*, *Claims Paid* and *Claims in Process* sections of the RA, immediately follow the ARCs, in a field marked **REMARKS**. A three-digit label at the beginning of each line of ARCs indicates which part of the claim the ARCs in that line pertain to, as follows:

- The line labeled 000 lists remark codes reported at the claim level.
- Lines labeled 001, 002 and so on list remark codes reported for the first, second, and subsequent service lines of the claim.

If no remarks were posted at the claim level or for a particular service line of the claim, the corresponding remark line does not appear on the RA.

Narrative descriptions of the remark codes used on an RA appear in the *Remark Code Descriptions* section of the RA (Figure 23). The *Remittance Advice Remark Codes* page at x12.org/codes contains a complete list of claim-specific adjustment remark codes.

> *Note: In the 835 transaction, the remark codes are aggregated at the claim and service-line level.*

Summary Page

The final page of the RA is the *Summary* page. This page provides a complete accounting of claim processing and payment activity for the current cycle and year-to-date. Table 4 lists each field and a description of the information contained in the field. Where applicable, the table also includes a description of how the information appears on the 835 transaction.

Each field and section name are preceded by a letter that corresponds to the location of that field or section in Figure 24, for easy cross-reference.

Table 4 – RA *Summary* Page Fields

Field	Description	835 Transaction Information
CLAIMS DATA *This section organizes the claims processed for this provider.* • CURRENT NUMBER and CURRENT AMOUNT reflect counts and dollars for the current cycle as reflected on this RA. • MONTH-TO-DATE NUMBER and MONTH-TO-DATE AMOUNT reflect counts and dollars processed during the current calendar month up to the date reflected on this RA. • YEAR-TO-DATE NUMBER and YEAR-TO-DATE AMOUNT reflect counts and dollars processed year-to-date for this provider, including the current cycle.		
A CLAIMS PAID	Number of paid claims processed. Total dollar amount paid for those claims.	
B CLAIM ADJUSTMENTS	Number of claims adjusted that resulted in increased payments. Additional dollar amount paid for the adjusted claims.	
C CLAIMS INTEREST	Amount of interest paid on clean electronic claims not processed within 21 days from receipt and clean paper claims not processed within 30 days from receipt.	• Claim level: AMT02 using a qualifier of **I** ➢ This segment appears in the claim loop, and the amount applies to the specific claim. • Provider level: PLB segment using a qualifier of **L6** ➢ The PLB segment contains the total number of claim interest days and total interest amount for all the claims that had interest for the provider.
D TOTAL CLAIMS PAYMENTS	Total of claims paid, claims adjustment and claim interest dollars. This amount ties to the Claims Payment line listed under the Earnings Data section.	
E CLAIMS DENIED	Total number of claims denied for payment.	

Field	Description	835 Transaction Information
F CLAIMS IN PROCESS	Total number of claims suspended for additional review.	
EARNINGS DATA *This section displays total amounts paid to the provider and the total earnings reflected for the provider.* • CURRENT AMOUNT reflects activity from this RA. • MONTH-TO-DATE AMOUNT reflects dollars processed during the current calendar month up to the date reflected on this RA. • YEAR-TO-DATE AMOUNT reflects total activity for this calendar year, including the activity specific to this RA.		
PAYMENTS		
G CLAIMS PAYMENTS	Sum total of claims paid, claims adjusted and claim interest dollars. This amount ties to the Total Claims Payment line listed under the Claims Data section.	
H MANAGED CARE ADMINISTRATIVE PAYMENT	Total amount paid for *Care Select* patients.* * The *Care Select* program ended July 31, 2015.	PLB A *Care Select* administrative fee payment is a provider-level adjustment. The PLB segment contains a system-generated administrative payment number and the amount.
I HOOSIER HEALTHWISE CAPITATION PAYMENT	*Applicable only for Hoosier Healthwise MCEs* Total capitation payment for members assigned to a Hoosier Healthwise MCE.	
J PATHWAYS CAPITATION PAYMENT	*Applicable only for Indiana PathWays for Aging (PathWays) MCEs* Total capitation payment for members assigned to a Hoosier Healthwise MCE.	
K HEALTHY INDIANA PLAN POWER ACCOUNT	*Applicable only for Healthy Indiana Plan (HIP) MCEs* Total HIP Personal and Wellness Responsibility (POWER) Account payment for members assigned to a HIP MCE.	
L HEALTHY INDIANA PLAN CAPITATION PAYMENT	*Applicable only for HIP MCEs* Total HIP capitation payment for members assigned to a HIP MCE.	
M NON EMERG MED TRANSP CAPITATION PAYMENT	*Applicable only for the IHCP-contracted nonemergency medical transportation (NEMT) management company* Total capitation payment for fee-for-service members assigned to brokered NEMT services.	
N PAYOUTS	Total amount of non-claim-specific payments included in the RA checkwrite total.	

Field	Description	835 Transaction Information
ACCOUNTS RECEIVABLE		
O CLAIM SPECIFIC	Amount deducted from the RA checkwrite for outstanding A/Rs tied to specific to claims. The two fields in this section are: • CURRENT CYCLE – Offsets related to adjustments reflected on the current RA. • OUTSTANDING FROM PREVIOUS CYCLES – Offsets related to adjustments that were processed in prior cycles and recouped in the current cycle.	
P NON CLAIM SPECIFIC	Amount deducted from the RA checkwrite for outstanding A/Rs that are not related to a given claim, not including offsets issued for financial adjustment reason code 8412 – *Partial payments.*	
REFUNDS		
Q CLAIM SPECIFIC ADJUSTMENT REFUNDS	Amount received from the provider and applied to a given prior-paid claim.	PLB This adjustment refund is a check-related, claim-specific cash-receipt, provider-level adjustment. The PLB segment contains the daughter claim ICN/Claim ID and the amount. For these types of adjustments, the ICN/Claim ID of the daughter claim begins with 51.
R NON CLAIM SPECIFIC REFUNDS	Amount the IHCP received in checks from the provider and applied against the provider's earnings, but not tied to a given prior-paid claim.	
OTHER FINANCIAL		
S MANUAL PAYOUTS	Amount reflects payments made to the provider outside *Core*MMIS, not included in any RA checkwrite total, but which must be included in total earnings.	
T VOIDS	Amount reflects IHCP payment checks returned to the Finance Unit uncashed.	PLB A void is a provider-level adjustment. The voided check number and amount appear as a positive or negative value on the PLB segment as required by the *835 Implementation Guide*. Void adjustments are not included in the provider payment amount; however, these adjustments are listed in the 835 transaction to inform the provider of the adjustment.
U MEMBER CONTRIBUTION (POWER)	Amount reflects the contributions the HIP member has paid toward their POWER Account.	

Field	Description	835 Transaction Information
V NET PAYMENT	Amount equals the total amount of the check if a payment is due, or is zero if the amount of offset is equal to the amount of payment due. The total is determined by adding claim payments, managed care payments and system payouts, and then subtracting claim-specific offsets, non-claim-specific offsets and partial payment recoveries offsets (such as A/Rs).	BPR02
W NET EARNINGS	Net IHCP paid amount. This amount is calculated by adding the net payment and manual payouts, and then subtracting claim-specific refunds, non-claim-specific refunds and voids. This total is the total reported to the IRS on the *1099*.	
OUTSTANDING CHECKS		
X CHECK NUMBER	Number of the paper check that was issued.	
Y ISSUE DATE	Date the checkwrite voucher is posted to the state accounting system. This is the Payment Date on the RA and paper checks.	
Z ISSUE AMOUNT	Amount of the payment issued.	
PAYMENTS TO LIEN HOLDERS *This section lists any payments made to lien holders that are deducted from the net payment made to the provider.*		
ZZ LIEN HOLDER NAME	Name of the entity receiving the lien amount withheld from the payee.	
ZZZ LIEN AMOUNT	Amount withheld from the payee's check and paid to the lien holder.	PLB A lien is a provider-level adjustment. The PLB segment contains a system-generated lien number and the amount.

Remittance Advice Examples

The following pages display examples of IHCP RA statements. The examples include claim adjudication pages for various types of claims. The examples are representative of what a provider might see on an RA. These examples are *not* a comprehensive listing for each claim type.

The numeric callouts beside each field in the following figures correspond to the fields described in Table 1. The alphabetic callouts in Figure 24 correspond to the fields described in Table 4.

Figure 4 – RA for Dental Claims Paid

```
REPORT:   CRA-DNPD-R                               INDIANA CORE MMIS                                  DATE:  MM/DD/CCYY
   RA#:   999999999                         <Financial Cycle Description>                             PAGE:       9,999
PAYER :   XXXX                                PROVIDER REMITTANCE ADVICE
                                                  DENTAL CLAIMS PAID


[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    [49]PAYEE ID       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                            [38]NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                            [51]PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                             [50]PAYMENT DATE        MM/DD/CCYY


              [68]RENDERING            SERVICE DATES    [15]BILLED AMT      [40]OTH INS AMT   [23]COPAY AMT   [45]PAID AMT
 [31]--ICN--      PROVIDER           [72]FROM  [73]TO     [10]ALLOWED AMT    [79]SPENDDOWN AMT   [20]CO-INS CB
[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX [35]MEMBER NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS  XXX XXXXXXXXXXXXXXX   MMDDYY  MMDDYY     9,999,999.99       9,999,999.99     999,999.99    9,999,999.99
                                                         9,999,999.99         999,999.99     999,999.99

[55]PROC CD[82]TOOTH[80]SURFACE [9]AREA OF ORAL CAV [76]SERVICE DATE  [52]PA NUMBER
               [22]COPAY AMT [16]BILLED AMT   [11]ALLOWED AMT [44]PAID AMT
 XXXXX     XX     XXXXX       XXXX             MMDDYY      XXXXXXXXXX
                  999,999.99  9,999,999.99    9,999,999.99  9,999,999.99 DATE
 XXXXX     XX     XXXXX       XXXX             MMDDYY      XXXXXXXXXX
                  999,999.99  9,999,999.99    9,999,999.99  9,999,999.99
 XXXXX     XX     XXXXX       XXXX             MMDDYY      XXXXXXXXXX
                  999,999.99  9,999,999.99    9,999,999.99  9,999,999.99
 XXXXX     XX     XXXXX       XXXX             MMDDYY      XXXXXXXXXX
                  999,999.99  9,999,999.99    9,999,999.99  9,999,999.99


[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                         TOTAL DENTAL CLAIMS PAID:      99,999,999.99     99,999,999.99   9,999,999.99    99,999,999.99
                                                        99,999,999.99      9,999,999.99   9,999,999.99
TOTAL NO. PAID:  999,999
```

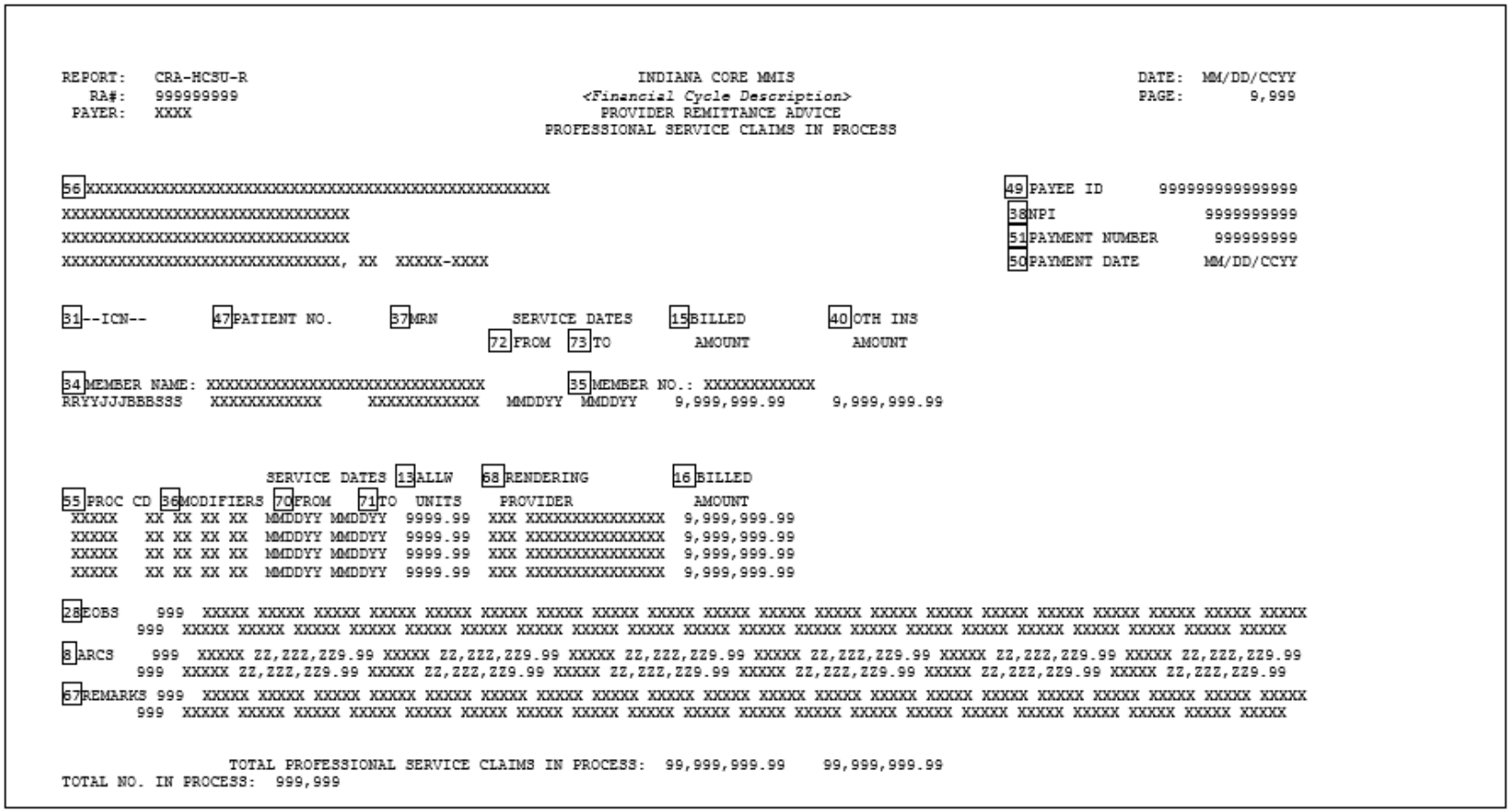
Figure 5 – RA for Professional Service Claims Paid

```
REPORT:   CRA-HCPD-R                                     INDIANA CORE MMIS                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                 <Financial Cycle Description>                                   PAGE:       9,999
 PAYER:   XXXX                                        PROVIDER REMITTANCE ADVICE
                                                   PROFESSIONAL SERVICE CLAIMS PAID

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [38] NPI                  9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                           [50]PAYMENT DATE       MM/DD/CCYY

[31]--ICN--   [47]PATIENT NUMBER   [37]MRN        SERVICE DATES   [15]BILLED AMT   [40]OTH INS AMT  [23]COPAY AMT     [45]PAID AMT
                                               [72]FROM  [73]TO     [10]ALLOWED AMT  [79]SPENDDOWN AMT  [20]CO-INS CB    [32]OUTPAT DED
[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX   MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                             9,999,999.99       999,999.99     999,999.99       999,999.99

                     SERVICE DATES [13]ALLW UNITS [68]RENDERING PROVIDER     [52]PA NUMBER
[55]PROC CD [36]MODIFIERS [70]FROM [71]TO   [22]COPAY AMT[16]BILLED AMT [11]ALLOWED AMT[44]PAID AMT
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                    TOTAL PROFESSIONAL SERVICE CLAIMS PAID: 99,999,999.99    99,999,999.99   9,999,999.99    99,999,999.99
                                                            99,999,999.99     9,999,999.99   9,999,999.99     9,999,999.99
TOTAL NO. PAID: 999,999
```

Figure 6 – RA for Professional Service Claims Denied

```
REPORT:  CRA-HCDN-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
  RA#:  999999999                      <Financial Cycle Description>                  PAGE:       9,999
 PAYER:  XXXX                            PROVIDER REMITTANCE ADVICE
                                      PROFESSIONAL SERVICE CLAIMS DENIED

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                             38 NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                             51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                          50 PAYMENT DATE       MM/DD/CCYY

 31 --ICN--       47 PATIENT NO.          37 MRN       SERVICE DATES     15 BILLED       40 OTH INS       79 SPENDDOWN
                                                      72 FROM  73 TO       AMOUNT          AMOUNT           AMOUNT

34 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35 MEMBER NO.:  XXXXXXXXXXXX
RRYYJJJBBBSSS    XXXXXXXXXXXX      XXXXXXXXXXXX    MMDDYY MMDDYY   999,999,999.99   9,999,999.99    999,999.99


                                  SERVICE DATES                    52 PA NUMBER
55 PROC CD 36 MODIFIERS 13 ALLW UNITS 70 FROM  71 TO   68 RENDERING PROVIDER 16 BILLED AMT
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                    9,999,999.99
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                  9,999,999.99

 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                  9,999,999.99
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                  9,999,999.99


28 EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
 8 ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
67 REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX


                    TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

Figure 7 – RA for Professional Service Claims in Process



```
REPORT:   CRA-HCSU-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Description>                    PAGE:       9,999
 PAYER:   XXXX                            PROVIDER REMITTANCE ADVICE
                                     PROFESSIONAL SERVICE CLAIMS IN PROCESS

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                              38 NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                              51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                               50 PAYMENT DATE       MM/DD/CCYY

31 --ICN--        47 PATIENT NO.      37 MRN        SERVICE DATES    15 BILLED         40 OTH INS
                                                  72 FROM  73 TO        AMOUNT           AMOUNT

34 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX          35 MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS   XXXXXXXXXXXX     XXXXXXXXXXXX   MMDDYY  MMDDYY    9,999,999.99     9,999,999.99


                      SERVICE DATES 13 ALLW   68 RENDERING          16 BILLED
55 PROC CD 36 MODIFIERS 70 FROM   71 TO  UNITS    PROVIDER             AMOUNT
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99

28 EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
8 ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
67 REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX


                TOTAL PROFESSIONAL SERVICE CLAIMS IN PROCESS:  99,999,999.99    99,999,999.99
TOTAL NO. IN PROCESS:  999,999
```

Figure 8 – RA for Professional Service Claim Adjustments

```
REPORT:   CRA-HCAD-R                              INDIANA CORE MMIS                               DATE:  MM/DD/CCYY
   RA#:   999999999                          <Financial Cycle Description>                        PAGE:        9,999
 PAYER:   XXXX                                PROVIDER REMITTANCE ADVICE
                                        PROFESSIONAL SERVICE CLAIM ADJUSTMENTS

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          [49]PAYEE ID      99999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  [38]NPI                 999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                   [50]PAYMENT DATE       MM/DD/CCYY

[31]--ICN--      [47]PATIENT NO.     [37]MRN      SERVICE DATES   [15]BILLED AMT   [40]OTH INS AMT   [23]COPAY AMT    [45]PAID AMT
                                              [72]FROM  [73]TO      [10]ALLOWED AMT   [79]SPENDDOWN AMT [20]CO-INS CB   [32]OUTPAT DED

[54]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX      XXXXXXXXXXXX   MMDDYY  MMDDYY   (9,999,999.99)   (9,999,999.99)   (999,999.99)   (9,999,999.99)
                                                                 (9,999,999.99)     (999,999.99)   (999,999.99)     (999,999.99)
RRYYJJJBBBSSS  XXXXXXXXXXXX      XXXXXXXXXXXX   MMDDYY M MDDYY     9,999,999.99     9,999,999.99    999,999.99     9,999,999.99
                                                                   9,999,999.99       999,999.99    999,999.99       999,999.99

                     SERVICE DATES[13]ALLW UNITS RENDERING PROVIDER      [52]PA NUMBER
[55]PROC CD [36]MODIFIERS  [70]FROM [71]TO   [22]COPAY AMT[16]BILLED AMT [11]ALLOWED AMT[44]PAID AMT
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99

                                                                [1]ADDITIONAL PAYMENT                     9,999,999.99
                                                                [43]OVERPAYMENT TO BE WITHHELD            9,999,999.99
                                                                [64]REFUND AMOUNT APPLIED                 9,999,999.99

ADJUSTMENT EOB:  9999

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

                     TOTAL PROFESSIONAL SERVICE CLAIMS ADJ:      99,999,999.99   99,999,999.99    9,999,999.99   99,999,999.99
                                                                 99,999,999.99    9,999,999.99    9,999,999.99    9,999,999.99
TOTAL NO. ADJ:  999,999
```

Figure 9 – RA for Inpatient Claims Paid

```
REPORT:   CRA-IPPD-R                                INDIANA CORE MMIS                                     DATE:  MM/DD/CCYY
   RA#:   999999999                          <Financial Cycle Description>                                PAGE:       9,999
 PAYER:   XXXX                                PROVIDER REMITTANCE ADVICE
                                                INPATIENT CLAIMS PAID


[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                               [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                        [38]NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                        [51]PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                          [50]PAYMENT DATE       MM/DD/CCYY

            [47]PATIENT NO.    SERVICE DATES [18]C DAYS [3]ADMIT  [15]BILLED AMT   [40]OTH INS AMT    [23]COPAY AMT  [32]INPAT DED    [45]PAID AMT
 [31]--ICN--       [37]MRN      [72]FROM [73]TO    [27]DRG CD   DATE  [10]ALLOWED AMT [79]SPENDDOWN AMT [41]OUTLIER AMT [20]CO-INS CB

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     [35]MEMBER NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS XXXXXXXXXXXX  MMDDYY MMDDYY   999     MMDDYY  9,999,999.99   9,999,999.99      999,999.99   999,999.99    9,999,999.99
               XXXXXXXXXXXX                  XXXX            9,999,999.99     999,999.99   9,999,999.99   999,999.99


           SERVICE DATES [13]ALLW UNITS   [52]PA NUMBER
  [59]REV CD [70]FROM [71]TO    [16]BILLED AMT  [11]ALLOWED AMT [44]PAID AMOUNT
    9999    MMDDYY MMDDYY   9999.99        XXXXXXXXXX
                            9,999,999.99  9,999,999.99  9,999,999.99
    9999    MMDDYY MMDDYY   9999.99        XXXXXXXXXX
                            9,999,999.99  9,999,999.99  9,999,999.99
    9999    MMDDYY MMDDYY   9999.99        XXXXXXXXXX
                            9,999,999.99  9,999,999.99  9,999,999.99
    9999    MMDDYY MMDDYY   9999.99        XXXXXXXXXX
                            9,999,999.99  9,999,999.99  9,999,999.99
    9999    MMDDYY MMDDYY   9999.99        XXXXXXXXXX
                            9,999,999.99  9,999,999.99  9,999,999.99

 [28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
          999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
 [8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
          999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
 [67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
          999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                           TOTAL INPATIENT CLAIMS PAID:    99,999,999.99  99,999,999.99    9,999,999.99 9,999,999.99  99,999,999.99
                                                           99,999,999.99   9,999,999.99   99,999,999.99 9,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 10 – RA for Outpatient Claims Paid

```
REPORT:   CRA-OPPD-R                                  INDIANA CORE MMIS                                         DATE:  MM/DD/CCYY
   RA#:   999999999                            <Financial Cycle Description>                                    PAGE:       9,999
 PAYER:   XXXX                                  PROVIDER REMITTANCE ADVICE
                                                 OUTPATIENT CLAIMS PAID

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    [49] PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           [38]NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           [51]PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                            [50]PAYMENT DATE        MM/DD/CCYY

                                              SERVICE DATES  [15]BILLED AMT      [40]OTH INS AMT   [23]COPAY AMT    [45]PAID AMT
 [31]--ICN--     [47]PATIENT NO.      [37]MRN     [72]FROM [73]TO        [10]ALLOWED AMT   [79]SPENDDDOWN AMT  [20]CO-INS CB  [42]OUTPAT DED

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS   XXXXXXXXXXXX   XXXXXXXXXXXX   MMDDYY MMDDYY     9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                                9,999,999.99       999,999.99     999,999.99       999,999.99

                    [36]MODIFIERS  [76]SERVICE DT  [13]ALLW UNITS  [52] PA NUMBER
 [69]REV CD [55]PROC CD [22]COPAY AMT[16]BILLED AMT  [11]ALLOWED AMT [44]PAID AMOUNT
    9999    XXXXX    XX XX XX XX  MMDDYY         9999.99        XXXXXXXXXX
                     999,999.99   9,999,999.99  9,999,999.99  9,999,999.99
    9999    XXXXX    XX XX XX XX  MMDDYY         9999.99        XXXXXXXXXX
                     999,999.99   9,999,999.99  9,999,999.99  9,999,999.99
    9999    XXXXX    XX XX XX XX  MMDDYY         9999.99        XXXXXXXXXX
                     999,999.99   9,999,999.99  9,999,999.99  9,999,999.99
    9999    XXXXX    XX XX XX XX  MMDDYY         9999.99        XXXXXXXXXX
                     999,999.99   9,999,999.99  9,999,999.99  9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
          999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
          999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[57]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
          999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                          TOTAL OUTPATIENT CLAIMS PAID:      99,999,999.99     99,999,999.99  9,999,999.99    99,999,999.99
                                                             99,999,999.99      9,999,999.99  9,999,999.99     9,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 11 – RA for Home Health Claims Paid

```
REPORT:   CRA-HHPD-R                              INDIANA CORE MMIS                              DATE:  MM/DD/CCYY
   RA#:   999999999                         <Financial Cycle Description>                        PAGE:       9,999
 PAYER:   XXXX                               PROVIDER REMITTANCE ADVICE
                                               HOME HEALTH CLAIMS PAID

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                            [50]PAYMENT DATE       MM/DD/CCYY

                                            SERVICE DATES [15]BILLED      [10]ALLOWED     [40]OTH INS      [48]PATIENT    [45]PAID
[31]--ICN--   [47]PATIENT NO.   [37]MRN    [72]FROM  [73]TO     AMOUNT          AMOUNT         AMOUNT          LIAB          AMOUNT

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS XXXXXXXXXXXX XXXXXXXXXXXX MMDDYY MMDDYY 9,999,999.99   9,999,999.99   9,999,999.99   999,999.99   9,999,999.99

                                   SERVICE DATES  [13]ALLW UNITS  [52]PA NUMBER
[69]REV CD [55]PROC CD  [36]MODIFIERS [70]FROM [71]TO   [16]BILLED AMT  [11]ALLOWED AMT  [44]PAID AMOUNT
 9999    XXXXX    XX XX XX XX  MMDDYY MMDDYY  9999.99       XXXXXXXXXX
                                              9,999,999.99  9,999,999.99  9,999,999.99

 9999    XXXXX    XX XX XX XX  MMDDYY MMDDYY  9999.99       XXXXXXXXXX
                                              9,999,999.99  9,999,999.99  9,999,999.99

 9999    XXXXX    XX XX XX XX  MMDDYY MMDDYY  9999.99       XXXXXXXXXX
                                              9,999,999.99  9,999,999.99  9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
          999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
          999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
          999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                              TOTAL HOME HEALTH CLAIMS PAID: 99,999,999.99  99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 12 – RA for Long Term Care Claims Paid

```
REPORT:   CRA-LTPD-R                               INDIANA CORE MMIS                                        DATE:  MM/DD/CCYY
  RA#:    999999999                          <Financial Cycle Description>                                  PAGE:       9,999
 PAYER:   XXXX                                 PROVIDER REMITTANCE ADVICE
                                               LONG TERM CARE CLAIMS PAID

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                 [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                 [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                  [50]PAYMENT DATE       MM/DD/CCYY

                                      SERVICE DATES [25]DAYS [21]COND [15]BILLED     [10]ALLOWED     [40]OTH INS     [48]PATIENT     [45]PAID
[31]--ICN--   [47]PATIENT NO.   [37]MRN     [72]FROM [73]TO          CODE    AMOUNT          AMOUNT          AMOUNT         LIAB           AMOUNT

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS XXXXXXXXXXXX XXXXXXXXXXXX MMDDYY MMDDYY 999   XX  9,999,999.99  9,999,999.99  9,999,999.99  999,999.99  9,999,999.99

                    SERVICE DATES [13]ALLW UNITS  [52]PA NUMBER
[69]REV CD [65]PROC CD [70]FROM [71]TO   [16]BILLED AMT  [11]ALLOWED AMT [44]PAID AMOUNT
 9999    XXXXX    MMDDYY MMDDYY  9999.99       XXXXXXXXXX
                                 9,999,999.99  9,999,999.99  9,999,999.99
 9999    XXXXX    MMDDYY MMDDYY  9999.99       XXXXXXXXXX
                                 9,999,999.99  9,999,999.99  9,999,999.99
 9999    XXXXX    MMDDYY MMDDYY  9999.99       XXXXXXXXXX
                                 9,999,999.99  9,999,999.99  9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                            TOTAL LONG TERM CARE CLAIMS PAID: 99,999,999.99  99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 13 – RA for Medicare Crossover Professional Service Claims Paid

```
REPORT:   CRA-XBPD-R                              INDIANA CORE MMIS                                       DATE:  MM/DD/CCYY
   RA#:   999999999                         <Financial Cycle Description>                                  PAGE:       9,999
 PAYER:   XXXX                                PROVIDER REMITTANCE ADVICE
                                    MEDICARE CROSSOVER PROFESSIONAL SERVICE CLAIMS PAID


[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              [38]NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                               [50]PAYMENT DATE       MM/DD/CCYY


                                        |-M  E  D  I  C  A  R  E   A M T S-|
  [31]--ICN--    [47]PATIENT NO.   SERVICE DATES   [24]COPAY AMT [12]ALLOWED AMT [57]PSYCH CO-INS  [15]BILLED    [23]COPAY AMT [32]OUTPAT DED [45]PAID AMT
                     [37]MRN        [72] FROM [73] TO    [46] PAID AMT  [26]DEDUCT     [19]CO-INS     [40]OTH INS AMT [79]SPENDDOWN   [20]CO-INS CB

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      [35]MEMBER NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS  XXXXXXXXXXXX  MMDDYY MMDDYY     999,999.99  9,999,999.99  999,999.99   9,999,999.99  999,999.99  999,999.99  9,999,999.99
                XXXXXXXXXXXX                  9,999,999.99    999,999.99  999,999.99   9,999,999.99  999,999.99  999,999.99


               [36]MODIFIERS   SER DT[70]FROM[71]TO[68]RENDERING PROV   [13]ALLW UNITS [52]PA NUMBER
[69]REV CD [55]PROC CD [22]COPAY AMT   [78]SPENDDOWN AMT [16]BILLED AMT  [11]ALLOWED AMT  [44]PAID AMT
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99


[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

TOTAL MEDICARE CROSSOVER PROFESSIONAL SERVICE CLAIMS PAID:
                                                  9,999,999.99 99,999,999.99  9,999,999.99    9,999,999.99  9,999,999.99 99,999,999.99
                                                 99,999,999.99  9,999,999.99  9,999,999.99   99,999,999.99 99,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 14 – RA for Medicare Crossover Institutional Claims Paid

```
REPORT:   CRA-XAPD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Descriptions>                   PAGE:       9,999
 PAYER:   XXXX                            PROVIDER REMITTANCE ADVICE
                                  MEDICARE CROSSOVER INSTITUTIONAL CLAIMS PAID


[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                               [50]PAYMENT DATE       MM/DD/CCYY

                          SERVICE DATES    |-M  E  D  I  C  A  R  E   A M T S-|

 [31]--ICN--  [47]PATIENT NO.[72]FROM [73]TO     [24]COPAY AMT  [17]BLOOD DEDUCT  [19]CO-INS [15]BILLED AMT [23]COPAY AMT[32]INPAT/OUTPAT DED[48]PATIENT LIAB

              [37]MRN    [3]ADMIT DT [25]DAYS   [46]PAID AMT     [26]DEDUCT          [40]OTH INS AMT [79]SPENDDOWN [20]CO-INS CB     [45]PAID AMT

 [34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSS  XXXXXXXXXXXX MMDDYY MMDDYY    999,999.99   999,999.99   999,999.99  9,999,999.99  999,999.99  999,999.99    999,999.99
              XXXXXXXXXXXX MMDDYY   999   9,999,999.99   999,999.99               9,999,999.99  999,999.99  999,999.99  9,999,999.99

[69]REV CD [55]PROC CD [36]MODIFIERS  SER DT [70]FROM[71]TO [68]RENDERING PROV  [13]ALLW UNITS [52]PA NUMBER

            [22]COPAY AMT  [78]SPENDDOWN AMT [16]BILLED AMT  [11]ALLOWED AMT    [44]PAID AMT

9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX

               999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

TOTAL MEDICARE CROSSOVER INSTITUTIONAL CLAIMS PAID:
                                    9,999,999.99  9,999,999.99 9,999,999.99 99,999,999.99 999,999.99 9,999,999.99  9,999,999.99
                                    9,999,999.99  9,999,999.99              99,999,999.99 999,999.99 9,999,999.99 99,999,999.99

TOTAL NO. PAID:  999,999
```

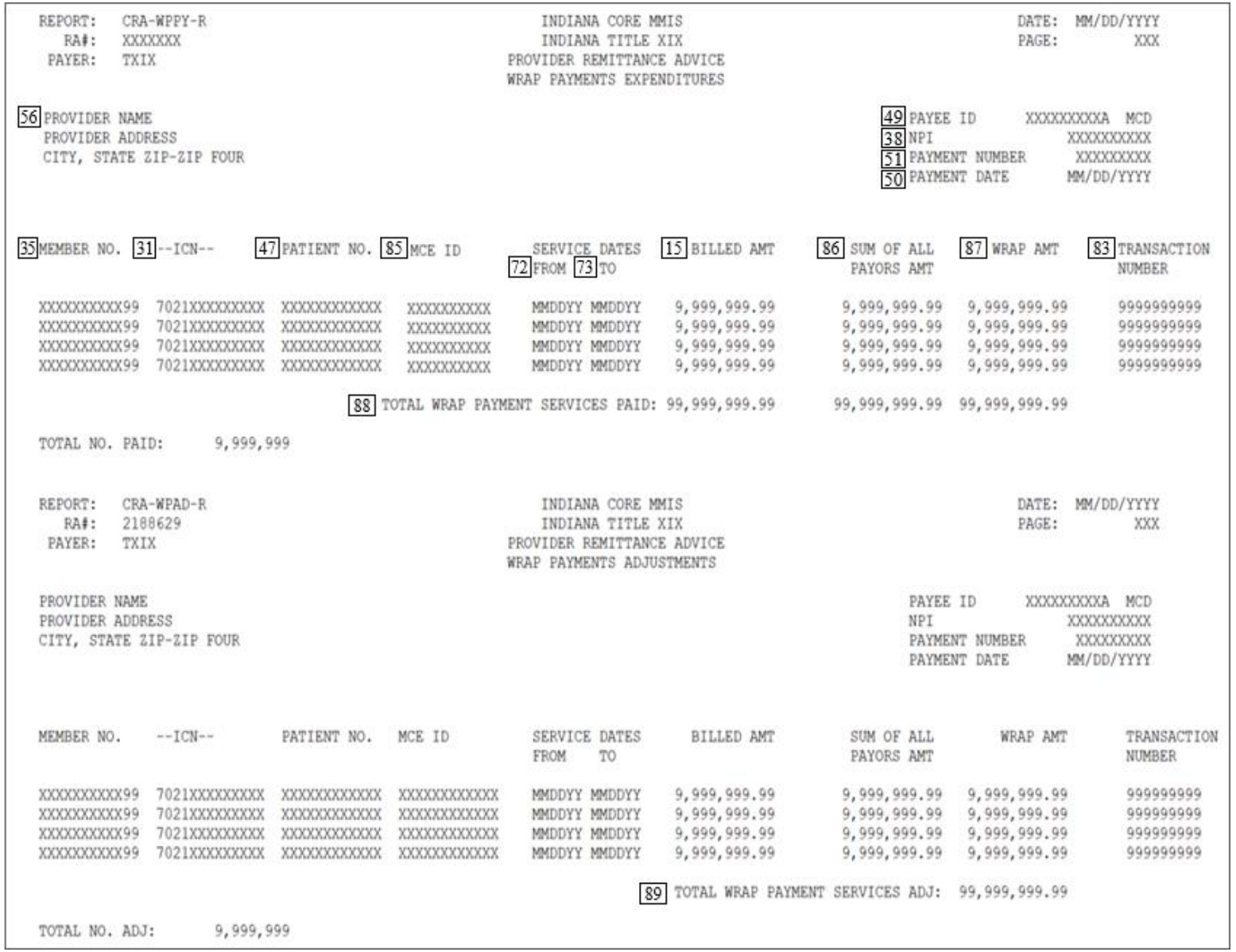
Figure 15 – RA Payment Hold

```
REPORT:   CRA-PEND-R                          INDIANA CORE MMIS                         DATE:  MM/DD/CCYY
   RA#:   999999999                     <Financial Cycle Description>                    PAGE:       9,999
 PAYER:   XXXX                            PROVIDER REMITTANCE ADVICE
                                                PAYMENT HOLD

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX               [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                      [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                      [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                        [50]PAYMENT DATE       MM/DD/CCYY


  THE FOLLOWING TRANSACTIONS WERE HELD DUE TO:

  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  REFERENCE NUMBER: 999999999


  [84]TRANSACTION TYPE       [31]ICN       [4]AMOUNT HELD

  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99

                 TOTAL AMOUNT HELD:   999,999,999.99

  THE FOLLOWING TRANSACTIONS WERE HELD DUE TO:

  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  REFERENCE NUMBER: 999999999


  [84]TRANSACTION TYPE       [31]ICN       [4]AMOUNT HELD

  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99

                 TOTAL AMOUNT HELD:   999,999,999.99

           GRAND TOTAL AMOUNT HELD: 9,999,999,999.99
```

Figure 16 – RA Medical Education Cost Expenditures and Medical Education Cost Adjustments

```
REPORT:   CRA-MEPY-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
  RA#:    999999999                      <Financial Cycle Description>                 PAGE:       9,999
 PAYER:   XXXX                             PROVIDER REMITTANCE ADVICE
                                         MEDICAL EDUCATION COST EXPENDITURES

 56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  49PAYEE ID      999999999999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        38NPI                9999999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        51PAYMENT NUMBER      999999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                     50PAYMENT DATE       MM/DD/CCYY

 51--ICN--      47PATIENT NO.    SERVICE DATES   15BILLED AMT   33MED ED AMT  83TRANSACTION NUMBER
                                 72FROM  73TO

 34MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35MEMBER NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXXXX      MMDDYY MMDDYY    9,999,999.99   9,999,999.99     9999999999

            90TOTAL MEDICAL EDUCATION COST PAID: 99,999,999.99  99,999,999.99

 TOTAL NO. PAID:        999,999


REPORT:   CRA-MEAD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
  RA#:    999999999                      <Financial Cycle Description>                 PAGE:       9,999
 PAYER:   XXXX                             PROVIDER REMITTANCE ADVICE
                                        MEDICAL EDUCATION COST ADJUSTMENTS

 56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  49PAYEE ID      999999999999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        38NPI                9999999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        51PAYMENT NUMBER      999999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                     50PAYMENT DATE       MM/DD/CCYY

  51--ICN--      47PATIENT NO.    SERVICE DATES   15BILLED AMT   33MED ED AMT  83TRANSACTION NUMBER
                                  72FROM  73TO

 34MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXXXX      MMDDYY MMDDYY    9,999,999.99   9,999,999.99     9999999999
  RRYYJJJBBBSSS  XXXXXXXXXXXX      MMDDYY MMDDYY   (9,999,999.99 )(9,999,999.99 )   9999999999

                  1ADDITIONAL PAYMENT                          9,999,999.99
                 43OVERPAYMENT TO BE WITHHELD                  9,999,999.99

                        91TOTAL MEDICAL EDUCATION COST ADJ: 99,999,999.99

TOTAL NO. ADJ:          999,999
```

Figure 17 – RA Wrap Payment Expenditures and Wrap Payment Adjustments (FQHC/RHC Medical Encounters)



```
REPORT:   CRA-WPPY-R                          INDIANA CORE MMIS                                  DATE:  MM/DD/YYYY
  RA#:    XXXXXXX                             INDIANA TITLE XIX                                  PAGE:       XXX
 PAYER:   TXIX                          PROVIDER REMITTANCE ADVICE
                                        WRAP PAYMENTS EXPENDITURES

[56] PROVIDER NAME                                                          [49] PAYEE ID      XXXXXXXXXA  MCD
   PROVIDER ADDRESS                                                         [38] NPI                XXXXXXXXXX
   CITY, STATE ZIP-ZIP FOUR                                                 [51] PAYMENT NUMBER      XXXXXXXXX
                                                                            [50] PAYMENT DATE       MM/DD/YYYY


[35] MEMBER NO.  [31] --ICN--      [47] PATIENT NO.  [85] MCE ID      SERVICE DATES  [15] BILLED AMT   [86] SUM OF ALL   [87] WRAP AMT   [83] TRANSACTION
                                                                     [72] FROM [73] TO                  PAYORS AMT                        NUMBER

  XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX    MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      9999999999
  XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX    MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      9999999999
  XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX    MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      9999999999
  XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX    MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      9999999999

                                                [88] TOTAL WRAP PAYMENT SERVICES PAID: 99,999,999.99      99,999,999.99  99,999,999.99

  TOTAL NO. PAID:      9,999,999


REPORT:   CRA-WPAD-R                          INDIANA CORE MMIS                                  DATE:  MM/DD/YYYY
  RA#:    2188629                             INDIANA TITLE XIX                                  PAGE:       XXX
 PAYER:   TXIX                          PROVIDER REMITTANCE ADVICE
                                        WRAP PAYMENTS ADJUSTMENTS

PROVIDER NAME                                                               PAYEE ID      XXXXXXXXXA  MCD
PROVIDER ADDRESS                                                            NPI                XXXXXXXXXX
CITY, STATE ZIP-ZIP FOUR                                                    PAYMENT NUMBER      XXXXXXXXX
                                                                            PAYMENT DATE       MM/DD/YYYY


MEMBER NO.    --ICN--        PATIENT NO.   MCE ID          SERVICE DATES     BILLED AMT       SUM OF ALL       WRAP AMT       TRANSACTION
                                                          FROM    TO                         PAYORS AMT                      NUMBER

XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      999999999
XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      999999999
XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      999999999
XXXXXXXXXX99  7021XXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY   9,999,999.99      9,999,999.99   9,999,999.99      999999999

                                                          [89] TOTAL WRAP PAYMENT SERVICES ADJ:  99,999,999.99

TOTAL NO. ADJ:       9,999,999
```

Figure 18 – RA Dental Wrap Payment Expenditures and Dental Wrap Payment Adjustments (FQHC/RHC Dental Encounters)

```
REPORT:   CRA-WDPY-R                          INDIANA CORE MMIS                          DATE:  MM/DD/YYYY
  RA#:    XXXXXXXX                            INDIANA TITLE XIX                          PAGE:          X
PAYER:    TXIX                              PROVIDER REMITTANCE ADVICE
                                          DENTAL WRAP PAYMENT EXPENDITURES

[56] PROVIDER NAME                                                          [49] PAYEE ID      XXXXXXXXXX MCD
   PROVIDER ADDRESS                                                         [38] NPI                XXXXXXXXXX
   CITY, STATE ZIP-ZIP                                                      [51] PAYMENT NUMBER     XXXXXXXXXX
                                                                            [50] PAYMENT DATE       MM/DD/YYYY

[35]MEMBER NO. [31]--ICN--    [47]PATIENT NO. [85]MCE ID     SERVICE DATES  [15] BILLED AMT  [86] SUM OF ALL  [87] WRAP AMT  [83]TRANSACTION
                                                [72]FROM [73]TO                  PAYORS AMT                      NUMBER

XXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXX XXXXXXXXX  XXXXXX XXXXXX     XXX.XX        XXX.XX        XXX.XX          XXXXX
XXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXX XXXXXXXXX  XXXXXX XXXXXX     XXX.XX        XXX.XX        XXX.XX          XXXXX

                          [88] TOTAL DENTAL WRAP PAYMENT SERVICES PAID:          XXX.XX        XXX.XX        XXX.XX

TOTAL NO. PAID:           X

REPORT:   CRA-WDAD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/YYYY
  RA#:    XXXXXXXX                            INDIANA TITLE XIX                          PAGE:          X
PAYER:    TXIX                              PROVIDER REMITTANCE ADVICE
                                          DENTAL WRAP PAYMENT ADJUSTMENTS

PROVIDER NAME                                                               PAYEE ID      XXXXXXXXXX MCD
PROVIDER ADDRESS                                                            NPI                XXXXXXXXXX
CITY, STATE ZIP-ZIP                                                         PAYMENT NUMBER     XXXXXXXXXX
                                                                            PAYMENT DATE       MM/DD/YYYY

MEMBER NO.    --ICN--       PATIENT NO.   MCE ID      SERVICE DATES     BILLED AMT       SUM OF ALL      WRAP AMT      TRANSACTION
                                                      FROM    TO                         PAYORS AMT                    NUMBER

XXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXX XXXXXXXXX  XXXXXX XXXXXX  (    XXX.XX )  (    XXX.XX ) (    XXX.XX )  XXXXXXXXX
XXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXX XXXXXXXXX  XXXXXX XXXXXX  (    XXX.XX )  (    XXX.XX ) (    XXX.XX )  XXXXXXXXX

                                                [89] TOTAL DENTAL WRAP PAYMENT SERVICES ADJ:      XXXXXXXXX

TOTAL NO. ADJ:            X
```

Figure 19 – RA Financial Transactions

```
REPORT:   CRA-TRAN-R                                    INDIANA CORE MMIS                                      DATE:  MM/DD/CCYY
   RA#:   999999999                              <Financial Cycle Description>                                 PAGE:       9,999
PAYER :   XXXX                                     PROVIDER REMITTANCE ADVICE
                                                     FINANCIAL TRANSACTIONS

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         [38]NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         [51]PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                          [50]PAYMENT DATE        MM/DD/CCYY

                              ---------------NON-CLAIM SPECIFIC PAYOUTS TO PAYEE---------------

  [83]TRANSACTION   [53]PAYOUT     [59]REASON  [30]FIN  SERVICE  DATE     [65]RELATED
       NUMBER         AMOUNT          CODE        ARC  [74]FROM  [75]THRU    PROVIDER ID
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999

  TOTAL PAYOUTS: 99,999,999.99

                              --------------NON-CLAIM SPECIFIC REFUNDS FROM PAYEE--------------

  [83]TRANSACTION   [63]REFUND     [60]REASON  [30]FIN      [51]PAYMENT [61]RECEIPT [34]MEMBER NAME      [35]MEMBER NO.
       NUMBER         AMOUNT          CODE       ARC           NUMBER      DATE
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX         999999999  MMDDYY   XXXXXXXXXXXX X X    XXXXXXXXXXXX

  TOTAL REFUNDS: 99,999,999.99
                              ----------------------ACCOUNTS RECEIVABLE----------------------

              [77]SETUP [39]ORIGINAL  [62]RECOUPMENT              [58]REASON[30]FIN[34]MEMBER NAME     [35]MEMBER NO. [2]ADJUSTMENT   [54]PREVIOUS    [5]AMOUNT RECOUPED
[6]A/R NUMBER     DATE     AMOUNT    AMOUNT TO DATE  [14]BALANCE      CODE  ARC                                     --ICN--         --ICN--        IN CURRENT CYCLE
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99

               TOTAL RECOUPMENT    99,999,999.99                                                                                            99,999,999.99
```

Figure 20 – RA EOB Code Descriptions

```
REPORT:   CRA-EOBM-R                         INDIANA CORE MMIS                                 DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Description>                           PAGE:       9,999
 PAYER:   XXXX                          PROVIDER REMITTANCE ADVICE
                                           EOB CODE DESCRIPTIONS

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                          [50]PAYMENT DATE       MM/DD/CCYY

[29]EOB CODE      [290]DESCRIPTION

  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 21 – RA Adjustment Reason Code Descriptions

```
REPORT:   CRA-ARCM-R                    INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999               <Financial Cycle Description>                    PAGE:       9,999
 PAYER:   XXXX                     PROVIDER REMITTANCE ADVICE
                                   ADJ REASON CODE DESCRIPTIONS

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                49PAYEE ID       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                     38NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                     51PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                       50PAYMENT DATE        MM/DD/CCYY

7ARC CODE     7DESCRIPTION

99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 22 – RA Service Code Descriptions

```
REPORT:   CRA-DESC-R                              INDIANA CORE MMIS                                    DATE:  MM/DD/CCYY
   RA#:   999999999                          <Financial Cycle Description>                             PAGE:       9,999
 PAYER:   XXXX                                 PROVIDER REMITTANCE ADVICE
                                               SERVICE CODE DESCRIPTIONS

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                      49 PAYEE ID     999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           38NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           51PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                            50PAYMENT DATE       MM/DD/CCYY

 81SVC CODE   81DESCRIPTION

  XXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 23 – RA Remark Code Descriptions

```
REPORT:   CRA-REMM-R                          INDIANA CORE MMIS                                          DATE:  MM/DD/CCYY
   RA#:   999999999                      <Financial Cycle Description>                                   PAGE:       9,999
 PAYER:   XXXX                             PROVIDER REMITTANCE ADVICE
                                            REMARK CODE DESCRIPTIONS

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                           49PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                38NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                51PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                 50PAYMENT DATE       MM/DD/CCYY

56REMARK CODE   56DESCRIPTION

99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 24 – RA Summary Page (Part 1 of 2)

```
REPORT:   CRA-SUMM-R                    Indiana Core MMIS                      DATE:  MM/DD/CCYY
   RA#:   999999999              <Financial Cycle Description>                 PAGE:      9,999
PAYER :   XXXX                    PROVIDER REMITTANCE ADVICE
                                            SUMMARY

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                 49PAYEE ID       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                       38NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                       51PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                       50PAYMENT DATE        MM/DD/CCYY
```

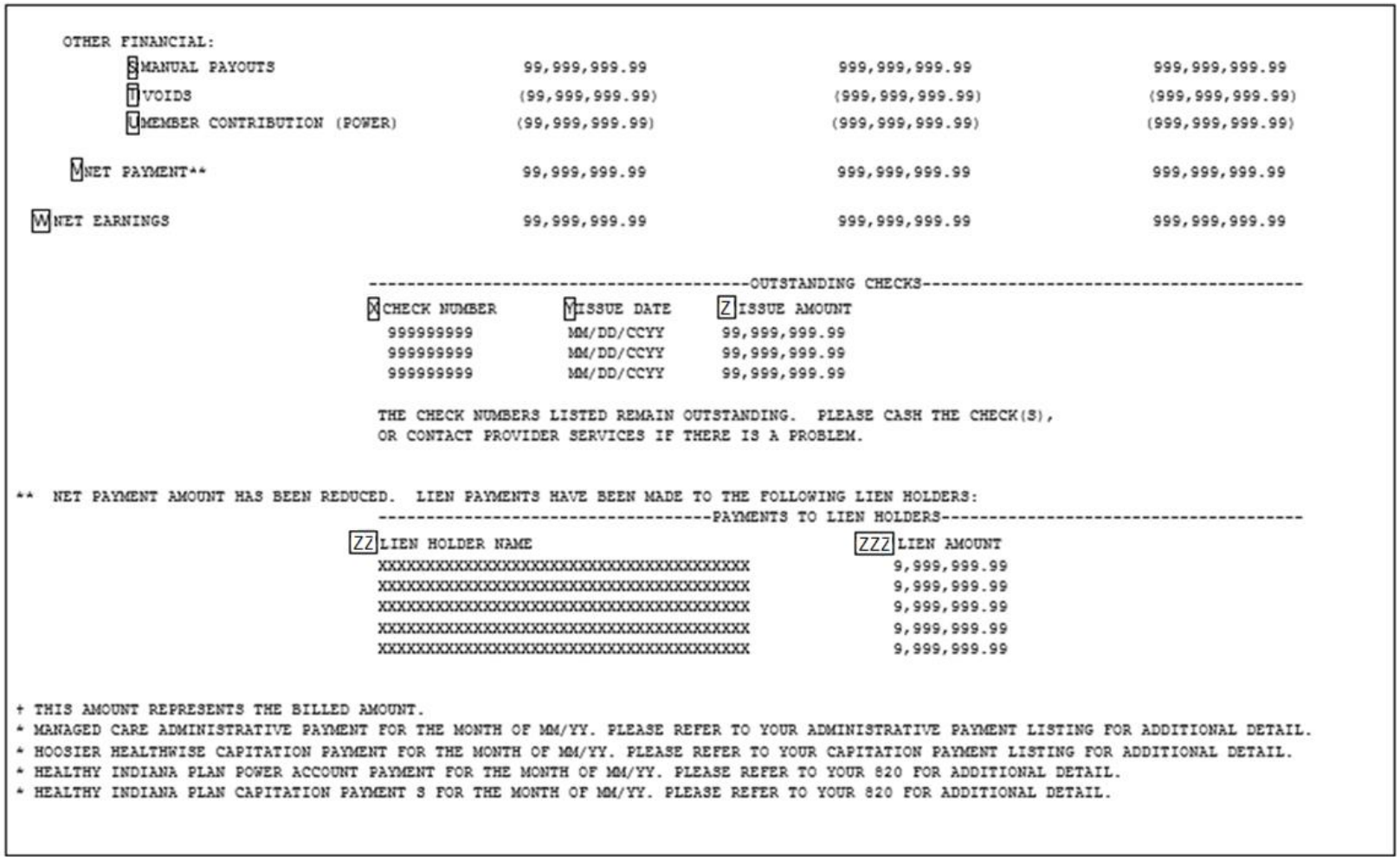
--CLAIMS DATA--

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
A CLAIMS PAID	999,999	99,999,999.99	9,999,999	999,999,999.99	9,999,999	999,999,999.99
B CLAIM ADJUSTMENTS	999,999	99,999,999.99	9,999,999	999,999,999.99	9,999,999	999,999,999.99
C CLAIMS INTEREST		99,999,999.99		999,999,999.99		999,999,999.99
D TOTAL CLAIMS PAYMENTS	999,999	99,999,999.99	9,999,999	999,999,999.99	9,999,999	999,999,999.99
E CLAIMS DENIED	999,999		9,999,999		9,999,999	
F CLAIMS IN PROCESS+	999,999	99,999,999.99				

--EARNINGS DATA--

	CURRENT AMOUNT	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE AMOUNT
PAYMENTS:			
G CLAIMS PAYMENTS	99,999,999.99	99,999,999.99	99,999,999.99
H MANAGED CARE ADMINISTRATIVE PAYMENT*	99,999,999.99	99,999,999.99	99,999,999.99
I HOOSIER HEALTHWISE CAPITATION PAYMENT*	99,999,999.99	99,999,999.99	99,999,999.99
J PATHWAYS CAPITATION PAYMENT*	99,999,999.99	99,999,999.99	99,999,999.99
K HEALTHY INDIANA PLAN POWER ACCOUNT*	99,999,999.99	99,999,999.99	99,999,999.99
L HEALTHY INDIANA PLAN CAPITATION PAYMENT*	99,999,999.99	99,999,999.99	99,999,999.99
M NON EMERG MED TRANSP CAPITATION PAYMENT*	99,999,999.99	99,999,999.99	99,999,999.99
N PAYOUTS	99,999,999.99	99,999,999.99	99,999,999.99
ACCOUNTS RECEIVABLE:			
O CLAIM SPECIFIC:			
CURRENT CYCLE	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)
OUTSTANDING FROM PREVIOUS CYCLES	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)
P NON-CLAIM SPECIFIC	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)
REFUNDS:			
Q CLAIM SPECIFIC ADJUSTMENT REFUNDS	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)
R NON CLAIM SPECIFIC REFUNDS	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)

Figure 24 – RA Summary Page (Part 2 of 2)



```
    OTHER FINANCIAL:
          SMANUAL PAYOUTS                    99,999,999.99          999,999,999.99          999,999,999.99
          TVOIDS                            (99,999,999.99)        (999,999,999.99)        (999,999,999.99)
          UMEMBER CONTRIBUTION (POWER)      (99,999,999.99)        (999,999,999.99)        (999,999,999.99)

       VNET PAYMENT**                        99,999,999.99          999,999,999.99          999,999,999.99

  WNET EARNINGS                              99,999,999.99          999,999,999.99          999,999,999.99


                                  ----------------------------------------OUTSTANDING CHECKS----------------------------------------
                                  XCHECK NUMBER       YISSUE DATE     ZISSUE AMOUNT
                                    999999999         MM/DD/CCYY      99,999,999.99
                                    999999999         MM/DD/CCYY      99,999,999.99
                                    999999999         MM/DD/CCYY      99,999,999.99

                                   THE CHECK NUMBERS LISTED REMAIN OUTSTANDING.  PLEASE CASH THE CHECK(S),
                                   OR CONTACT PROVIDER SERVICES IF THERE IS A PROBLEM.


**  NET PAYMENT AMOUNT HAS BEEN REDUCED.  LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS:
                                  ----------------------------------PAYMENTS TO LIEN HOLDERS----------------------------------
                                ZZLIEN HOLDER NAME                                                  ZZZLIEN AMOUNT
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            9,999,999.99
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            9,999,999.99
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            9,999,999.99
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            9,999,999.99
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            9,999,999.99

+ THIS AMOUNT REPRESENTS THE BILLED AMOUNT.
* MANAGED CARE ADMINISTRATIVE PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR ADMINISTRATIVE PAYMENT LISTING FOR ADDITIONAL DETAIL.
* HOOSIER HEALTHWISE CAPITATION PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.
* HEALTHY INDIANA PLAN POWER ACCOUNT PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR 820 FOR ADDITIONAL DETAIL.
* HEALTHY INDIANA PLAN CAPITATION PAYMENT S FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR 820 FOR ADDITIONAL DETAIL.
```

Comparison of the 835 Transaction and Remittance Advice

The RA reports only dollar amounts without balancing concerns. This dollar amount reflects prior payment information, including TPL and Medicare payments, or Medicare coinsurance, copayment or deductible as submitted with the original claim.

The CAS segments of the 835 transaction use different methods of reporting adjustments. Per the Data Overview Section of the *005010X221 – 835 Health Care Claim Payment/Advice Transaction, Version 5010 Implementation Guide Section 1.10.1.4 – Remittance*, "The 835 must be balanced whenever remittance information is included in an 835 transaction." *Section 1.10.2.1 – Balancing*, in the same section of the *835 Implementation Guide*, states: "The amounts reported in the 835, if present, MUST balance at three different levels." Because the guide does not address the issue of populating the 835 CAS segments, the decision was made to use the method described in the 4050 draft version of the 835 guide. Per this guide, the IHCP reports – for balancing purposes – only the amount of prior payment, TPL, and Medicare payments or Medicare coinsurance, copayment or deductible in the 835 transaction, up to the amount that would have been paid for the service.

Accounts Receivable and Other Provider-Level Adjustments and Financial Transactions

The following sections explain accounts receivable (A/R) as well as other provider-level adjustments (payouts and refunds) that are not related to a specific claim. These adjustments are reported to providers as follows:

- On the RA, these financial transactions are reported in the *Financial Transactions* section (Figure 19), including the associated reason code and financial ARC. They are also listed under the appropriate headings on the Summary page (Figure 24).
- Within the electronic 835 transaction format, these financial transactions are reported at the provider level using the financial ARCs and may only appear when they are applied or when claim activity is present.

The financial ARCs are two-character alphabetical codes associated with nonclaim financial transactions and activities that increase or decrease the net payment amount associated with the weekly RA.

Accounts Receivable

An accounts receivable (A/R) is money determined by the FSSA or one of its contractors to be payable to the IHCP from an enrolled provider. A/Rs may also occur when a provider has adjusted a claim or requested a claim adjustment.

Establishing Accounts Receivable

*Core*MMIS automatically establishes a separate A/R for *every* adjustment when the net reimbursement of an adjustment is less than the original payment. For all system-generated A/Rs, the ICN/Claim ID of the original claim, the member's name and Member ID (also known as RID) are also reflected on the RA.

The second method for establishing an A/R is manual setup. Common reasons for manual setups are repayment agreements, tax assessments for intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and community residential facilities for the developmentally disabled (CRFs/DD), quality assessments for nursing facilities, hospital assessment fees (HAFs), and Program Integrity audits.

Accounts Receivable Reason Codes

For each A/R reason code returned on the RA, the associated EOB and its description are printed in the *EOB Descriptions* section of the RA, under the heading AR EOB CODE.

The following are examples of some of the most commonly used A/R reason codes:

- 8400 – *A/R – Result of claim adjustment*
- 8405 – *A/R – Manual setup (Tax Assessments-Monthly)*
- 8406 – *A/R – Manual setup (Unspecified)*
- 8416 – *A/R – Result of retro-rate adjustment*
- 8463 – *A/R – Manual setup (Nursing facility monthly quality assessment)*
- 8494 – *A/R – Manual setup (Monthly Hospital Assessment Fee)*

ICF/IID Tax Assessments

ICF/IID and CRF/DD facilities are charged a monthly tax assessment. Myers and Stauffer determines the assessment in conjunction with the rate-setting process and forwards the information to the Finance Unit along with the rate for a given period.

The monthly assessment appears as an A/R with the reason code of 8405 and the associated financial ARC. Within the 835 transaction, the A/R appears as a provider-level adjustment with a financial ARC assigned to the amount.

When the Finance Unit receives retroactive notification of a rate change, the notification also provides the change in the tax assessment amount. When the change is received, the Finance Unit reconciles the amount due based on the rate change to the amount collected. Based on an increase or decrease in the assessment amount, the Finance Unit initiates an A/R to collect additional money due if the assessment increased or a payout to return money over collected if the assessment decreased.

Recovery of Accounts Receivable

The following four methods are used to recoup A/Rs:

1. The first method is the claim offset process, which occurs when a provider filing a claim for reimbursement has a portion of the amount owed on the A/R systematically deducted from its weekly RA payment until the full amount is recouped. When the A/R is systematically created by *Core*MMIS or manually by the financial analyst, a recoupment date is established that is the effective date for recoupment. Based on this information, *Core*MMIS automatically begins deducting payment from the provider's RA.
2. The second method occurs when a provider recognizes that an overpayment exists and sends a refund check to offset the A/R. When submitting a refund check, the provider must refer to any applicable ICNs/Claim IDs, member identification numbers, member names and A/R control numbers to ensure proper handling.
3. The third method for recovery of A/Rs involves a repayment agreement between the IHCP and the provider owing money to the FSSA. This repayment agreement allows the provider to make installment payments for up to, but not more than, a six-month period to refund the FSSA for overpayments. This method typically occurs only when the provider owes especially large sums of money causing financial hardship, and alternate sources of outside financing have been unsuccessful. The Family and Social Services Administration (FSSA) must approve each repayment agreement. See the *Partial Payments and Repayment Agreements* section for instructions on how to submit a repayment agreement request.

> *Note: Each provider and service location can have only one open repayment agreement at a time.*

4. The fourth method is used when an A/R is established under the Provider ID and it is determined that the number is not actively enrolled in the IHCP. If other Provider IDs share the same taxpayer identification number (TIN), the A/R is transferred to the active Provider IDs. This action may also occur voluntarily when a provider requests the account be transferred to another active Provider ID.

Accounts Receivable Referrals

If an A/R has not been recovered after 15 days, the Finance Unit mails either a transfer letter or a demand letter, as follows:

- Transfer letter (Figure 25) – If the provider with the outstanding A/R shares a common TIN with another provider, the Finance Unit mails a **transfer letter** to the pay-to address of the Provider ID with the same TIN, as notification that the A/R will be transferred to that provider. If the recipient of the transfer letter does not respond in 10 days, the A/R is transferred to that provider to recoup the amount owed.
- Demand letter (Figure 26) – If the provider with the overdue A/R does not share a common TIN with another provider, the Finance Unit mails a **demand letter** to the provider's pay-to address. If the provider was issued a demand letter and the A/R is still open after 15 days, a request for a referral to the Office of the Attorney General may be sent to the FSSA. To avoid referrals to the Office of the Attorney General for legal action, providers must remit payment within 15 days of receipt of the demand letter.

Figure 25 – Transfer Letter

GAINWELL TECHNOLOGIES
PO BOX 50458
INDIANAPOLIS, IN 46250-0418

Eric Holcomb, Governor
State of Indiana
Indiana Health Coverage Programs
800-457-4584
www.in.gov/medicaid

Date: 11/4/2024

<<Addressee Name>>
<<Addressee Address>>
<<Addressee City/State/ZIP>>

Re: Outstanding Accounts Receivable Provider Number

Dear Provider,

Our records indicate that your **Tax Identification Number xxxxxxxxx** has outstanding accounts receivable under ***Provider ID xxxxxxxxx x***, your tax entity remains responsible for this repayment.

Gainwell Technologies is prepared to transfer the accounts receivable amount of **$xxxx.xx** to your Provider ID ***Provider ID xxxxxxxxx x.*** Please contact our office to discuss this matter and its resolution. If our office does not hear from you within **10 calendar days** from the date of this letter, the transfer will occur automatically on **xx/xx/xxxx.** Once this transfer occurs, the amount will be deducted from future remittance advices until the account(s) receivable is satisfied.

Your assistance in resolving this matter is appreciated. Please contact the Gainwell Technologies Finance Unit at (317) 488-5004, should you have any questions regarding this letter.

Sincerely,

Finance Unit

Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect
Hoosier Healthwise • Indiana PathWays for Aging • Traditional Medicaid

Figure 26 – Demand Letter (Page 1 of 2)

GAINWELL TECHNOLOGIES
PO BOX 50458
INDIANAPOLIS, IN 46250-0418

Eric Holcomb, Governor
State of Indiana
Indiana Health Coverage Programs
800-457-4584
www.in.gov/medicaid

Date: 11/4/2024

<<Addressee Name>>
<<Addressee Address>>
<<Addressee City/State/ZIP>>

Provider Number(s): «Provider ID_»
Re: Outstanding Account(s) Receivable

Dear Provider,

This letter is a follow-up to a previous remittance advice sent regarding the outstanding account(s) receivable (A/R) under ***LPI «Provider ID_»***. If you bill on a regular basis, the money will be recouped from your future payments until satisfied. You are receiving this letter because there has been insufficient submission of claims at this time. The full amount of the outstanding account(s) receivable is ***$«AMOUNT»***

If you do not bill regularly and the repayment activity has not occurred on this account(s) receivable within the required period, you need to send a check to the address below. This letter serves as an official request for the repayment of the outstanding balance of your account(s) receivable. Please remit payment for ***$«AMOUNT»*** and a copy of this letter to the following address:

Gainwell – Refunds
PO Box 2303, Dept 130
Indianapolis, IN 46206-2303

Responses should be postmarked no later than **10 calendar days** from the date of this letter, on which date your complete provider file and enrollment packet will be prepared for transfer to the Office of Medicaid Policy and Planning (OMPP) within three business days. It is the intent of the OMPP to make a referral to the Office of Indiana Attorney General for collection. Any documentation that will conclusively refute the amount owed must be submitted prior to the date above.

A survey is included on the back of this letter for you to indicate the status of your receivable. If you are currently working with Gainwell Technologies staff to resolve outstanding issues, please be aware that we will complete that work before any case is referred for collection. If your receivable has already been satisfied prior to your receipt of this letter, you do not need to respond to this letter.

A survey is included on the back of this letter for you to indicate the status of your receivable.

Your assistance in resolving this matter is appreciated. Please contact the Gainwell Technologies Finance Unit at 317.488.5004, should you have any questions regarding this letter.

Sincerely,

Finance Unit

Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect
Hoosier Healthwise • Indiana PathWays for Aging • Traditional Medicaid

Figure 26 – Demand Letter (Page 2 of 2)

GAINWELL TECHNOLOGIES
PO BOX 50458
INDIANAPOLIS, IN 46250-0418

Eric Holcomb, Governor
State of Indiana
Indiana Health Coverage Programs
800-457-4584
www.in.gov/medicaid

Date: 11/4/2024

PLEASE INDICATE BELOW THE CURRENT STATUS OF YOUR RECEIVABLE:

☐ Check enclosed, $_____.

☐ Check will be sent by _____. (Date check will be mailed.)

☐ Working with Gainwell Technologies Finance Unit, _____ (Analyst Name)

☐ Working with Gainwell Technologies Field Consultant, _____ (Consultant Name)

☐ Transfer to *ACTIVE* Legacy Provider Number & Location: _____

☐ Corporation dissolved as of _____ (Date of Dissolution).
Forward a copy of the corporation dissolution documentation.
Owner's Name and Telephone Number: _____

☐ Corporation has been sold as of _____ (Date of Sale).
Forward a copy of the Purchase Agreement.

☐ Previous owner's name/telephone number:

_____

☐ Current owner's name/telephone number:

_____

☐ Bankruptcy filed as of _____ (Date), filed in _____ County. Provide a copy of the Bankruptcy Notice.

☐ Provider deceased as of _____ (Date). Please supply a copy of the death certificate and additional documentation if the Estate is open.

☐ Retired as of _____ (Date).

☐ Contact name/telephone number:

_____

Name/Title/Telephone Number of Person Completing Form:

_____

_____

Date: _____

Return form to Gainwell Technologies Finance Unit, PO Box 50458, Indianapolis, IN 46250

Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect
Hoosier Healthwise • Indiana PathWays for Aging • Traditional Medicaid

Partial Payments and Repayment Agreements

A partial payment and repayment agreement may be issued to a provider at the direction of, or after approval by, the FSSA when a provider has proven that significant claim-processing issues are causing undue financial hardship and alternate sources of outside financing have been unsuccessful. Repayment agreements may be the result of, but are not limited to, mass adjustments and retro-rate adjustments.

The maximum amount that a provider may request for a repayment agreement is five-sixths of the total amount owed, to be repaid over a maximum of six months. For example, if the provider is requesting a five-month repayment agreement, the maximum partial payment to the provider is four-fifths of the total amount owed, and so forth.

A provider may have only one repayment agreement per Provider ID at any given time.

The following steps outline the process for establishing a repayment agreement:

1. To request a repayment agreement, the provider must mail a letter on the provider's letterhead to the Gainwell Finance Unit:

   Finance Manager
   Gainwell – Finance Unit
   PO Box 50458
   Indianapolis, IN 46250-0418

   The letter must contain the following information:

   - Provider name
   - Provider ID
   - Provider *pay-to* address

   > *Note: The pay-to address must match the information currently displayed in CoreMMIS. If there is a discrepancy, the provider must update this information before any further actions occur.*

   - Provider contact name, title and telephone number
   - Reason for the request of a repayment agreement detailing specific reasons for financial hardship
   - Length of desired agreement (not to exceed six months)
   - Amount of the requested agreement
   - Statement indicating the facility has attempted to secure funds from its lending institution for this amount

   > *Note: A copy of the declination letter from the financial institution must be included with the submission.*

   - Detailed and specific account of the reasons for the request
   - Statement as to the status of a pending action, including a change of ownership (CHOW), bankruptcy filing, or facility closing that is currently taking place or may occur within the six months following the date of the request
   - Copy of the provider's latest financial statement or cost report
2. After receiving the written request, the Finance Unit performs a review of the information.
3. Upon verifying compliance with the required conditions, the Finance Unit drafts a repayment agreement and submits it to the FSSA for review.
4. The FSSA makes a determination to approve or deny the agreement:
   - If the FSSA does not grant approval for a repayment agreement, the Finance Unit contacts the provider regarding the denial.
   - If the FSSA grants approval and returns the agreement, with signature, the Finance Unit sends a copy of the agreement to the provider to sign.

5. The provider signs the approved agreement and returns it by mail to the Finance Unit.
6. Upon receipt of the signed copy from the provider, the Finance Unit executes the agreement.

Figure 27 shows an example of a payment and recoupment agreement.

Figure 27 – Payment and Recoupment Agreement (Page 1 of 2)

Indiana Health Coverage Programs (IHCP) Payment and Recoupments Agreement
For XXXXXXXXX X

NOTE TO PROVIDERS: This request cannot be considered or executed without a written request submitted to Gainwell Technologies LLC on the provider's letterhead detailing the rationale for its request for a repayment agreement. The Office of Medicaid Policy and Planning (OMPP) will consider each request based on the information provided. The IC 12-15-23-2 is the authority for entering into agreements to deduct overpayments from subsequent payment. ***The terms of such agreements can never exceed six months and interest must be collected. See 405 IAC 1-1-5(g).***

____ A) This repayment agreement is for a system offset
____ B) This repayment agreement is for manual (check) reimbursement

This agreement has been entered into by Provider Name, Address, City, State, ZIP (hereinafter "Provider") and the Office of Medicaid Policy and Planning, State of Indiana (hereinafter OMPP) through its fiscal contractor, Gainwell Technologies LLC (hereinafter Gainwell), PO Box 50458, Indianapolis, IN 46250-0418.

By execution of this Agreement, the undersigned Provider agrees to the payment terms and conditions specified herein.

The Terms and Conditions of this Agreement are as follows:

1. The Provider has requested a payment plan based upon future Medicaid payments in the amount of **$Amount** for the reason set forth on the Provider Payment Plan Form (attached and incorporated herein by reference). The OMPP has approved said request.

2. _____ **A) System Offset:** The Provider agrees to permit Gainwell to begin recoupment of the monies owed against its Medicaid payments on **date**. Such recoupments shall take place against remittances issued to the Provider beginning on **date** until the payment is fully recouped. At this rate, the entire payment will be recouped by **date**. The provider agrees to permit Gainwell to automatically recoup all outstanding manual reimbursement for accounts receivables setup that are greater than 15 days old under this agreement. **If full payment is not received within 15 calendar days from the due date, the agreement will be placed in default and subject to immediate and full recoupment.**

   _____ **or B) Manual Payment:** The Provider agrees to begin repayment to the OMPP (via Gainwell) of the monies owed against its Medicaid payments on **date**. Such payments shall take place **rate (monthly, weekly, etc)** beginning on **date** until the payment is fully recouped. At this rate, the entire repayment will be made by **date**. Gainwell should receive payment on or before the due date. If payment is not received within 15 calendar days from the due date, the agreement will be placed in default and subject to immediate and full recoupment.

3. The Provider agrees that if the recoupment has not been completed by **date**, the remaining balance is immediately due and that the Provider shall remit the full balance to Gainwell by **date** (*ten days after the expected full recoupment date*). If payment is not received once the accounts receivable has aged 15 days and the provider is submitting claims for payment, Gainwell will begin offsetting dollars at 100 percent until payment is fully recouped.

4. The Provider shall immediately notify Gainwell Provider Enrollment of any change in address, location, provider number, or status of ownership or control of the undersigned entity. If the OMPP is notified that the facility will be closing or if the provider will no longer be submitting claims under Provider **# Provider ID**, as a result of the closure, change of ownership (CHOW), or control of the undersigned entity, the Provider agrees to remit the outstanding balance of the payment to Gainwell or Gainwell shall begin offsetting the total balance beginning with the claims immediately following such notice or CHOW.

5. The Provider agrees that should it file a bankruptcy petition at some future date before recoupment of this payment in accordance of this agreement is complete, recoupment in accordance with this agreement shall be considered an equitable exception from the automatic stay under 11 U.S.C. 362. The provider shall not oppose any action by the OMPP to continue recoupment.

6. Should the business submitting claims as Provider **# Provider ID** cease to exist as a legal entity due to a change in ownership status, Provider **# Provider ID** shall be responsible for any current and future liabilities that may result from retro-rate adjustments or any other accounts receivable that are the subject of this agreement unless the new owner agrees

Repayment Agreement - Page 1 of 2
Date: Date
Provider Number: Provider ID

Figure 27 – Payment and Recoupment Agreement (Page 2 of 2)

Indiana Health Coverage Programs (IHCP) Payment and Recoupments Agreement
For XXXXXXXXX X

in writing to be liable for any amounts due the State of Indiana. The Provider may not assign or transfer the Provider's liabilities under this agreement without the prior written consent of the OMPP. In the absence of evidence of such a written agreement between the Provider and the new owner, the Provider's owners, corporate officers, and/or Board of Directors agree that they are jointly and severally liable for repayment of any and all liabilities arising from the relationship between the Provider and Indiana Medicaid.

7. Should the business submitting claims as Provider **# Provider ID** default on any terms of this agreement or fail to repay the full amount by **date,** the provider agrees to pay any costs of collection including, but not limited to, attorney fees and court costs.

8. The Provider and the OMPP agree that any modifications to this agreement shall only be made in writing and signed by both parties.

WHEREOF, the parties have executed this Agreement.

To be completed/signed by provider	**To be signed by Gainwell**	**To be signed by OMPP**
Provider Representative Signature*	Gainwell Finance Director Signature	OMPP Representative Signature
Provider Representative Printed Name	Gainwell Financial Analyst Signature	OMPP Representative Printed Title
Provider Representative Printed Title/Contact Phone Number		
Company Name DBA		
Company Corporate/Legal Entity (if different from above DBA)		
Address Corporate/Legal Entity		
Tax ID Legal Entity (if different from provider tax ID)		
Date	Date	Date

The individual signing this form must be an employee or officer who can legally bind the company to this agreement.

FOR GAINWELL USE ONLY

Date Received	Initial Analyst Assigned	All Documentation Included?	Proceed with Repayment Agreement?
		☐Yes ☐ No	☐Yes ☐ No

Repayment Agreement - Page 2 of 2
Date: Date
Provider Number: Provider ID

Non-Claim-Specific Payouts

Payouts occur when providers are due refunds from the IHCP that cannot be tied to a specific claim transaction. Payouts are initiated any time refunds are due to providers but the refunds cannot be tied to specific claims. Reasons for refunds include, but are not limited to the following:

- Overpayments when a provider submits a check after claims are offset
- Repayment agreements approved by the FSSA

Except in the instances of partial provider payments and repayment agreements, payout requests are initiated by the Finance Unit, Myers and Stauffer, or the FSSA, and do not require the provider to submit any additional documentation or requests. For more information on requesting provider partial payments, see the *Partial Payments and Repayment Agreements* section.

Within the 835 transaction, payouts are assigned a financial ARC as a provider-level agreement.

The RA lists payouts on the *Financial Transactions* page, under NON-CLAIM SPECIFIC PAYOUTS TO PAYEE. A transaction number is listed for each payout; providers should refer to this internal tracking number when calling the Customer Assistance Unit for more information.

Next to the transaction number is the payout amount, followed by a reason code that identifies why the payout was made to a provider. For each payout reason code returned on the RA, the associated EOB and its description are printed in the *EOB Descriptions* section of the RA, under the heading EXP EOB CODE.

The following is a list of the most common non-claim-specific payout reason codes:

- 8302 – *Payout Due to an Over Refund*. This reason code indicates that a provider issued a check to the IHCP to refund monies the provider believed were due to the IHCP. However, the check was more than the actual amount due, and the payout is initiated to return excess monies to the provider. Payouts using this reason code also display a number under the CCN field, which reflects the CCN assigned to the provider's refund check when the Finance Unit received it.
- 8304/8305 – *Payout Due to a Partial Payment*. These reason codes indicate that a partial provider payment and repayment agreement have been requested and approved by the FSSA. If reason code 8304 is displayed, the partial payment monies are included in the total amount being paid to the provider in this weekly RA. If reason code 8305 displays, the provider previously received a manual check, outside the RA, for the partial payment of monies.
- 8306 – *Check Received by Gainwell for Claim Adjustment on Previously Adjusted Claim*. *Amount of Refund Being Returned to Provider*. This reason code is used when the Finance Unit receives a refund from a provider that cannot be applied because the corresponding claim has already been adjusted. The refund is returned to the provider.

After the payout reason code, the RA lists the financial ARC, service dates and related Provider ID.

The total payout amount is listed on the Summary page of the RA.

Payouts are included in the provider's net earnings for the year and are reflected in *1099* reporting to the provider and the IRS.

Non-Claim-Specific Refunds

Money repaid by a provider that cannot be tied to a specific claim is considered a non-claim-specific refund. A provider can return money not related to a specific claim for the following items:

- A/R repayments
- Program Integrity audits when the random sampling method was used to identify the overpayment
- Provider's internal audit identifies IHCP overpayments, but specific claims cannot be identified

Within the 835 electronic transaction, refunds appear assigned to financial ARCs as provider-level adjustments.

The RA lists refunds on the *Financial Transactions* page, under NON-CLAIM SPECIFIC REFUNDS FROM PAYEE. Each refund is listed with a transaction number and the refund amount, followed by a reason code that identifies how the refund was applied. For each refund reason code returned on the RA, the associated EOB and its description are printed in the *EOB Descriptions* section of the RA, under the heading CASH EOB CODE.

The following is a list of the most commonly used non-claim-specific refund reason codes:

- 8220 – *Refund due to Third Party Liability*. If the provider indicates that a refund is due the IHCP after payment is received from a third party, this reason code is used.
- 8223 – *Surveillance Utilization Review (SUR) Audit*. If the provider indicates a repayment of the principal owed on a Program Integrity audit finding, this reason code is used. Program Integrity audit refunds are only non-claim-specific when the random sampling method is used. If a Program Integrity audit finds specific claims to be repaid, those refunds are posted as claim specific. The *Claim Adjustments* module provides more information on claim-specific adjustments.
- 8224 – *Audit Interest.* If the provider indicates a repayment of the interest due on a Program Integrity audit finding, this reason code is used.
- 8229 – *Non-claim Refund – Unspecified.* Refund check with insufficient documentation to apply to a given claim was received from a provider. A check was applied against a provider's earnings but not to a particular claim.
- 8438 – *A/R Repayment*. If the provider indicates a repayment of an outstanding A/R, this reason code is used.

After the refund reason code, the RA lists the financial ARC, payment number, receipt date, member name and Member ID. The total payout amount for non-claim-specific refunds is listed on the Summary page of the RA.

Non-claim-specific refunds are deducted from the provider's net earnings for the year and are reflected on *1099*s.

Liens Against Provider Payments

The Finance Unit is responsible for handling liens against provider payments. These liens originate from the IRS or court orders. The Finance Unit enters the liens in *Core*MMIS. As a result, providers can see net payments reduced by the amount of the lien, or the entire amount due can be forwarded to the lien holder.

The Finance Unit receives notification from the IRS by a Notice of Levy or by a court order for garnishments. When it receives such notification, the Finance Unit identifies all providers that share the TIN affected by the lien. The amount of the lien is entered in *Core*MMIS and payments are forwarded to the lien holder until the full amount of the lien has been satisfied, the lien has been released, or the lien requirements have been satisfied.

Liens appear on the RA *Summary* page under the *Payments to Lien Holders* section (see Figure 24, Part 2). The lien holder's name and the amount paid to the lien holder in the current cycle are included in this section. On the 835 electronic transaction, the lien amount (whenever present) appears only as the current paid amount as a provider-level adjustment using a financial ARC.

An additional provider-level adjustment that can occur is a backup withholding. If a provider is subject to backup withholding, the information displays in the *Payments to Lien Holders* section of the RA *Summary* page. More information on the backup withholding process is included in the *Backup Withholding* section. In the 835 transaction, backup withholding appears as a current provider-level adjustment with an assigned financial ARC only.

While payments can be made to the lien holders, the provider's *1099* reflects the full amount of all net payments regardless of any amounts forwarded to lien holders.

For a provider to be released from a lien, one of the following must occur:

- The full amount of the lien must have been collected and forwarded to the lien holder.
- If it is an IRS-ordered lien, the Finance Unit may receive a Release of Lien from the IRS for a continuous levy or may close the lien after the levy requirements have been satisfied.
- If it is a court-ordered lien, the Finance Unit must receive a court order indicating that any court order of garnishment can now cease.

FQHC/RHC Wraparound Payment for Professional and Dental Encounter Claims

Federally qualified health center (FQHC) and rural health clinic (RHC) medical and dental encounter wraparound (supplemental) payments for services rendered to IHCP managed care members are systematically processed on a claim-by-claim basis by Gainwell Technologies.

*Core*MMIS will systematically process the wraparound payment and display the wraparound amounts on the weekly RA. Wraparound payments and adjustments are listed for each applicable claim processed for the week, and are grouped separately for medical and dental claims (see Figure 17 and Figure 18).

IHCP Payment Check Processing

Each week, the Finance Unit compiles claim payments and non-claim-specific transaction information processed by *Core*MMIS and issues an RA or 835 transaction to the provider. If a payment is due to the provider and the provider is not using EFT, an IHCP payment check is sent by U.S. Mail. See the *Electronic Funds Transfer* section or more information on how to enroll for EFT payments.

This section describes the actions that can occur after the IHCP payment check is issued. These actions include the following:

- Stop payment and reissue of IHCP payment checks
- Stale-dating of IHCP payment checks
- Voiding of IHCP payment checks

Stop Payment and Reissue Requests

Occasionally, a provider may not receive an IHCP payment in a timely manner, and a check reissue is required. In this situation, a stop-payment request is appropriate. Providers should allow two weeks (14 calendar days) before submitting a reissue request to allow for delivery delays from the U.S. Postal Service. The following steps describe the stop-payment and reissue process.

1. The provider calls the Customer Assistance Unit toll-free at 800-457-4584 to request that an IHCP check be reissued.

   Providers must be prepared to confirm the *pay-to* address when requesting that an IHCP payment be reissued. Gainwell will not reissue a check or an EFT if the *pay-to* address listed in *Core*MMIS is incorrect. To have the *pay-to* address updated, providers must submit an *IHCP Provider Name and Address Maintenance Form* (available from the *Update Your Provider Profile* page at in.gov/medicaid/providers) or use the IHCP Portal to update their information on file. This update is important to ensure that the check can be reissued and that future checks are delivered promptly.
2. After receiving the reissue request, the Finance Unit verifies the records to determine whether the check was returned to Gainwell to be voided. If the check was returned to Gainwell with instructions to be voided, all claims associated with that check were voided. The provider must resubmit relevant claims to adjudicate claims. Checks that are voided cannot be reissued.
3. If the Finance Unit does not have a record of the check being returned as undeliverable or voided, Gainwell notifies the bank to stop payment on the original check number.
4. If the original check has not been presented for payment and honored by Gainwell's bank, the bank places a stop payment on the check.
5. Gainwell reissues the payment with a different check number and forwards the reissued check to the provider. Again, the *pay-to* address must be confirmed and correct before a check can be reissued.

If the provider receives the original check after a reissuance has been requested, the provider should write *VOID PREVIOUSLY REQUESTED* on the front of the check and mail the original check to the following address:

Gainwell – Finance Unit
PO Box 50458
Indianapolis, IN 46250-0418

Providers are responsible for informing the Provider Enrollment Unit of all address changes through the *IHCP provider packet* or by using the IHCP Portal. Failure to update the information in a timely manner can result in delays in payment and can cause the provider to have to request a check reissuance. The *Provider Enrollment* module provides more information about address changes.

Providers are encouraged to consider EFT, which deposits IHCP payments automatically into the appropriate account each week. EFT prevents lost checks and decreases the time required to receive payments. More information about EFTs is included in the *Electronic Funds Transfer* section.

Stale-Dated Checks

Checks are issued and mailed to IHCP providers weekly. If a check is not presented for payment at Gainwell's bank within six months after the date of issuance, the check is stale-dated at the bank and will not be honored for payment. After a check becomes stale-dated, Gainwell voids the check and any associated claims from *Core*MMIS.

A provider in possession of a stale-dated check should write *VOID – STALE-DATED* across the face of the check and return it to the following address:

Gainwell – Finance Unit
PO Box 50458
Indianapolis, IN 46250-0418

After returning a stale-dated check to the Finance Unit, the provider must resubmit any claims paid with that check to Gainwell for processing to receive payment.

The administrative burden for the provider increases when a check becomes stale-dated. Providers are encouraged to cash checks in a timely manner to prevent stale-dating and to decrease resubmission of claims. An alternative to receiving checks, which also prevents stale-dating, is to enroll in the EFT option. The *Electronic Funds Transfer* section provides more information about EFT.

Voiding an IHCP Payment Check

A provider that receives an IHCP payment check and wants to return the entire amount can return the check for voiding to the following address:

Gainwell – Finance Unit
PO Box 50458
Indianapolis, IN 46204-4288

A provider can initiate voiding a check for a number of reasons. These reasons include, but are not limited to, the following:

- The members listed on the RA are not patients of the provider receiving the check.
- The wrong provider received the payment.
- The IHCP previously paid claims listed on the RA.
- The claims listed on the RA were paid for a provider not with the group that received payment.
- The payment was made payable to the wrong location or provider identification number.
- The check is older than six months from the date of issue and is stale-dated.

Claim adjustments do not require a check to be voided. A provider that has been overpaid or underpaid on a claim cannot return the check to be voided and reissued with a different dollar amount. The provider must submit an adjustment request as outlined in the *Claim Adjustments* module.

Voiding a check voids all transactions, including claims, associated with that check. When a check is voided, it cannot be stopped or replaced. The claims associated with that check must be resubmitted for processing. The void process removes the associated claim payments from the provider's *1099* amount.

Information about voided checks appears on the last page of the RA. The amount voided appears in the CURRENT AMOUNT column of the VOIDS line (under OTHER FINANCIAL). This amount is also added in the YEAR-TO-DATE column of this line. For *1099* reporting purposes, the voids are deducted from the provider's total year-to-date amount by subtracting the year-to-date VOIDS amount from the year-to-date NET PAYMENT amount.

Electronic Funds Transfer

Through EFT, IHCP payments are deposited directly into a provider's designated bank account, rather than being sent by paper check. EFT significantly reduces the amount of time providers must wait to receive payment for IHCP services. The Finance Unit deposits provider payments by electronic media in the bank account of the provider's choice. EFT eliminates mailing time from the Finance Unit to the provider's mailing address, manual deposit at the provider's bank, the possibility of the check being stale-dated because it was not deposited in a timely manner, and any delays crediting the funds to the provider's account that may be imposed by banking institutions. EFT is a safe, efficient and cost-effective means of enhancing practice management accounts receivable (A/R) procedures.

The EFT is accomplished using Automated Clearing House (ACH) transactions from the IHCP's bank to the provider's bank. The ACH file that is sent to the provider's bank includes the ACH addenda record, per the recommendation outlined in the *835 Implementation Guide*. Providers can choose to accept the ACH addenda record from their banks. The *835 Health Care Claim Payment/Advice Transaction* companion guide on the *IHCP Companion Guides* page at in.gov/medicaid/providers includes the ACH value in BPR04 and CCP in BPR05 when the provider has EFT and also receives 835 transactions.

Providers participating in the EFT option receive RAs with printed check numbers beginning with a **9**. Payments beginning with **9** on the RA have been directly deposited.

> *Note: Providers that use EFT continue to receive RA statements on the IHCP Portal. Providers that choose the 835 electronic transaction may select either paper check or EFT.*

How to Enroll in the IHCP Electronic Funds Transfer Option

EFT is only available for billing providers. Rendering providers do not have an EFT option.

Billing providers can establish EFT payments by entering their EFT information on the IHCP Portal (**My Home > Provider Maintenance > EFT Changes**). IHCP-enrolled providers can register for the IHCP Portal by selecting the IHCP Provider Healthcare Portal link from the homepage of the IHCP provider website at in.gov/medicaid/providers and then clicking **Register Now**.

Alternatively, providers can submit a completed *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form*, available for download from the *Update Your Provider Profile* page at in.gov/medicaid/providers, to the Provider Enrollment Unit.

To start, cancel or change EFT payments, providers must include the following on the EFT form:

- The correct provider profile information, including NPI, TIN and IHCP Provider ID (in the Assigning Authority field)
- The applicable financial institution information, including the bank's American Bankers Association (ABA) transit routing number
- A specific bank account number and the type of account, such as checking or savings
- The reason for submission (type of authorization being initiated): new enrollment, change enrollment or cancel enrollment
- Signature of an authorized official or a delegated administrator listed with the Provider Enrollment Unit on a Schedule C.3 or a Delegated Administrator Addendum.

EFT forms must be submitted to the following address:

IHCP Provider Enrollment Unit
PO Box 50443
Indianapolis, IN 46250-0418

Providers should retain copies of the EFT forms for their records.

> *Note: It takes approximately four weeks for EFT information to be processed by Gainwell and validated by the provider's bank. Submitting an incomplete form delays the initiation, cancelation or change of the EFT.*

How an EFT Is Established With the Provider's Bank

When Gainwell receives and processes the completed form, *Core*MMIS sends a test transmission to the provider's bank. If the information in *Core*MMIS matches the information on the bank's records, EFT begins within three payment cycles.

If the information provided on the EFT form is not acceptable, the provider's bank sends an exception report to Gainwell. The report is verified against the provider's EFT form and *Core*MMIS for accuracy.

If the mismatch is a result of a keying error, Gainwell corrects the error and resumes testing. If the mismatch is a result of the information submitted by the provider, Gainwell contacts the provider to resolve the problem.

Until the EFT process is accepted by the providers' bank, providers continue to receive weekly IHCP payment checks.

EFT Rejections

EFTs routinely occur without intervention from the provider; however, providers are encouraged to verify with their banks each week that EFTs have been received. If EFTs have not been received by Thursday, providers should contact the Customer Assistance Unit toll-free at 800-457-4584.

While providers should verify deposit of the funds each week and can notify the Customer Assistance Unit of any problems, Gainwell is also notified by its bank if an EFT is not accepted by the receiving bank. The most common reasons EFTs are rejected include: incorrect routing or ABA numbers, incorrect account numbers, closure of the receiving account, or routing to a savings account when it is a checking account.

Confirm the ABA routing number that appears on a deposit ticket submitted with an EFT request before mailing the request to Gainwell or before entering the EFT information into the IHCP Portal. Deposit ticket routing numbers can vary from the actual routing number assigned to a customer's bank account. If there are any questions regarding the correct routing number, the bank should be contacted to verify prior to entering into the IHCP Portal or submitting an update form.

It is crucial for the provider to immediately update any change in bank information with the Provider Enrollment Unit to help prevent EFTs from being rejected. See the *How to Cancel EFT Participation or Change EFT Information* section. Gainwell cancels EFT information that caused a rejection so that future EFTs are not attempted using that information. When EFT is canceled, a provider receives a weekly check until the provider reapplies for EFT status.

When notified the receiving bank has rejected an EFT, Gainwell reissues payment to the provider within the same week by paper check until the EFT information is updated. Providers receive these funds by a separate check that indicates which EFT it is replacing.

How to Cancel EFT Participation or Change EFT Information

Billing providers can use the IHCP Portal or the *IHCP Provider Electronic Funds Transfer Addendum/ Maintenance Form* to start, cancel or change an EFT. See the *How to Enroll in the IHCP Electronic Funds Transfer Option* section for more information on completing the form or making changes online.

After Gainwell processes the cancellation, providers will receive weekly IHCP payment checks.

> *Note: It takes approximately four weeks for EFT information to be processed by Gainwell and validated by the provider's bank.*

If a provider is changing EFT information, but not canceling EFT altogether, the provider should not close one EFT account until a second account has been activated, unless the provider changes its *pay-to* address to receive a payment check during the interim.

Refunds to the IHCP

If a provider owes money to the IHCP, the provider can write a check for the amount due and forward that check for processing. In some instances, as outlined in the *IHCP Payment Check Processing* section of this document, providers can choose to return the IHCP payment check uncashed.

Documentation Required

All checks issued as refunds to the IHCP must be accompanied by the appropriate documentation, such as a paid claim adjustment form or a copy of the RA showing the A/R being repaid. If proper documentation is not provided, the check can be incorrectly applied, or the provider can experience delays in posting a check while this documentation is obtained.

All checks issued as payment for products, such as provider modules, fee schedules or software, must be accompanied by a purchase request.

IHCP providers must submit checks and associated documentation correctly for checks and check-related adjustments to process accurately and efficiently. Gainwell scans check-related adjustments. For documentation to be imaged clearly, completely and correctly, observe the following guidelines:

- Do not highlight the member's name or other information on submitted documentation. When documentation is scanned, the scanned image appears in black and white only. Highlighted information appears blacked out on the scanned image and is not readable.
- Use an asterisk next to the claim to be adjusted. Other options include circling member information on the EOB or blacking out all information not related to the specific request.
- Do not staple the check to the documentation.
- Do not put adhesive notes on the documentation. When scanned, the note may cover up important information necessary to adjust the claim.
- When submitting more than one check and accompanying documentation, place the documentation for each check behind the check to which it relates. Include a cover sheet on the documentation to indicate the number of checks being submitted.

Where to Send Checks

Checks issued as repayments for monies owed the IHCP that are related to Program Integrity must be made payable to **IHCP** and mailed to the Office of Medicaid Policy and Planning (OMPP) at the following address:

IHCP Program Integrity
PO Box 636297
Cincinnati, OH 45263-6297

Checks issued as repayments for amounts owed to the IHCP that are not related to Program Integrity must be made payable to **IHCP** and mailed to the following address (with the appropriate documentation specifying why the check is being submitted):

Gainwell – Refunds
P.O. Box 2303, Dept. 130
Indianapolis, IN 46206-2303

Mail IHCP payment checks returned uncashed to be voided to the following address (include documentation as to why the check is being returned):

Gainwell – Finance Unit
PO Box 50458
Indianapolis, IN 46250-0418

Remit refund checks for pharmacy adjustments to the following address:

Courier Mail:

Optum Rx Claims
LBX 26594
JP Morgan Chase
131 S. Dearborn – 6th Floor
Chicago, IL 60603

First-Class Mail:

Optum Rx Claims
26594 Network Place
Chicago, IL 60673-1265

If you have further questions regarding pharmacy, see the *Pharmacy Services* module.

> *Note: Do not send completed claim forms to these addresses for processing. Doing so results in processing delays. Mail completed claim forms to the appropriate post office box as outlined in the Claim Submission and Processing* module.

Internal Revenue Service Reporting Requirements

The IHCP is subject to the same rules and regulations as all other payers. As such, the program is required to report payments made to providers annually through the *1099* reporting process. Additionally, the program is required to perform backup withholding on provider payments if notification is given that information on the *1099* form does not match IRS records.

1099 Reporting

The IHCP is required to produce *1099s* for all entities that received more than $600 in payments in the prior calendar year. This information is reported to the IRS. Each *1099* must be postmarked by January 31 of each calendar year.

To determine what information is printed on the *1099* and reported to the IRS, *Core*MMIS accumulates all payments made to a given TIN. These payments include claim-specific payments and non-claim-specific payouts.

The TIN used in reporting is the one the provider supplied on the *W-9* form submitted with the *IHCP provider packet*. The name used for *1099* reporting is the *legal* name supplied on the same *W-9* form.

To prevent *1099* information from being reported incorrectly and to avoid the possibility of backup withholding, providers must update their IHCP provider profile information on a timely basis and confirm that the information currently on file is correct. Providers can obtain a copy of the *W-9* form from the *Update Your Provider Profile* page at in.gov/medicaid/providers or by contacting the IRS.

It is critical that providers do not allow other providers to submit claims using their provider numbers. Providers using the wrong provider number or allowing others to use the provider number may experience significant tax and accounts receivable problems later.

1099 Correction Requests

A provider that receives an incorrect *1099* must request a review of the *1099* in writing at the following address:

Financial Analyst
Gainwell – Finance Unit
1099 Processing
PO Box 50458
Indianapolis, IN 46250-0418

A copy of the *1099* in question and any documentation supporting the requested change is required.

The Finance Unit must receive requested changes no later than March 1 to issue a corrected *1099.* If the Finance Unit determines that a corrected *1099* should be issued, it issues a new *1099,* if the request was received by March 1. When information has been filed with the IRS (by March 1), all corrections are updated in the provider's file and used for future reporting to the IRS.

B-Notice Process

The *B-Notice* is a letter indicating that the name and TIN a provider submitted on the *W-9* was incorrect, according to IRS records.

Twice a year, in the spring and in the fall, the IRS compares the TIN and the name supplied by Gainwell to IRS records. If the taxpayer name and number combination do not match, the IRS notifies Gainwell, and the Finance Unit generates a *B-Notice*.

For the first *B-Notice*, the notice, a blank *W-9* and a self-addressed envelope are mailed to the provider's home office (legal) address with instructions for completion. If a provider receives a second *B-Notice* within three calendar years, the notice requires the provider to obtain a *147C* form by contacting the IRS or the Social Security office. **Both types of *B-Notices* include a deadline for documentation to be completed and received by the Finance Unit**. If the Finance Unit does not receive the documentation by the date shown on the *B-Notice*, Gainwell is required to begin backup withholding from the provider's payments.

Backup Withholding

Backup withholding is the process Gainwell uses to forward the required percentage (set by the IRS) of the provider's net payment to the IRS as a tax payment. The amount withheld is forwarded to the IRS weekly and is tied to a specific TIN. These amounts appear on the provider's *1099.*

If a provider is subject to backup withholding, the *Payments to Lien Holders* section on the last page of the RA (see Figure 24) will list **Withholding** under Lien Holder Name, with the amount withheld as the Lien Amount.

Gainwell can stop backup withholding only after receiving the required documentation from the provider. Required documentation can be mailed to the following address:

Financial Analyst
Gainwell – Finance Unit
1099 Processing
PO Box 50458
Indianapolis, IN 46250-0418

> *Note: Gainwell cannot refund money that has been withheld from a provider and forwarded to the IRS.*

It is imperative that providers receiving a *B-Notice* from Gainwell respond promptly with the appropriate documentation stated in the *B-Notice* to avoid backup withholding.