

- The University of Illinois at Chicago, Division of Specialized Care for Children (UIC-DSCC) operates the Home Care Program on behalf of the Department of Healthcare and Family Services (HFS). A claim will be considered for payment only if it is received by UIC-DSCC no later than 180 days from the date on which services are provided. This time limit applies to both initial and resubmitted claims. Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid. Claims, for which the Illinois Medicaid is not primary payer, must be submitted to UIC-DSCC within 180 days after the final adjudication by the primary payer.
- Claims should not be submitted to UIC-DSCC until all weekly timesheets have been received for all nursing shifts worked for the standard billing week.
- Dates of service billed must be in accordance with the standard billing week which begins Sunday at 12:00 a.m. and ends Saturday at 11:59 p.m.
- Monthly Resource Allocation claims must be split at the end of the calendar month.
- The normal billing day is 12:00 a.m. to 11:59 p.m. Nursing hours are to be reported on the calendar day they are worked. EXAMPLE: When a shift is from 11:00 p.m. to 7:00 a.m., 11:00 p.m. to 11:59 p.m time must be listed on one calendar day and the remaining hours reported on the following calendar day.
- Hours from individual work shifts for the same date of service are to be combined by procedure code prior to submitting claims for the standard billing week. EXAMPLE: If an RN worked 7-3 and another RN worked 11-12, enter 36 units T1002.
- Respite hours are to be billed after the child has exhausted the approved nursing services.
- Billing rates cannot exceed the rates approved by HFS on the 2352.
- All nursing services provided to the child by the nursing agency or school should be reflected on the billing form.
- HFS is payer of last resort minus any hours paid by the primary insurance.
- The nursing agency or family is responsible for submitting claims to the insurance company. Payment for approved nursing services in accordance with the Medical Plan of Care for children shall not be made until insurance has paid or rejected the claim.
- All services billed to the insurance company must be submitted to UIC-DSCC. Claims should be submitted with a copy of the insurance carrier's Explanation of Benefits (EOB) as soon as insurance determination has been received. Claims where insurance payments exceed the rates approved by HFS will be considered paid in full.
- Verification of services provided must be documented, signed by the client, and nurse or certified nurse assistant and maintained by the agency for review upon request.
- Verify all information and calculations are correct.

**Claims submitted that are not in accordance with the billing requirements will be returned to the provider to make the appropriate corrections and will delay payment.**

1. PROVIDER NAME

2. PROVIDER NUMBER

3. PROVIDER INVOICE NO.

4. PROVIDER BILLING ADDRESS

5. CITY, STATE, ZIP

6. CHILD'S NAME (FIRST, MI, LAST)

7. SITE ADDRESS (CITY, STATE, ZIP)

8. PRIOR APPROVAL

9. RECIPIENT NUMBER

10. DSCC NUMBER

11. BIRTHDATE

**12. SERVICE SECTIONS**

PROCEDURE DESCRIPTION	PROC CODE	MODIFIERS
<input type="text"/>	<input type="text"/>	<input type="text"/>
DATE OF SERVICE      UNITS/QTY	INSURANCE AMT	PROVIDER CHARGE
<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
REPEAT      PROCEDURE DESCRIPTION	PROC CODE	MODIFIERS
<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
DATE OF SERVICE      UNITS/QTY	INSURANCE AMT	PROVIDER CHARGE
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<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

**15. CERTIFICATION:**  
 By signature I certify the above billing is an accurate report of service hours rendered and hourly rates billed are in accordance with the Medical Plan of Care approved by Illinois Department of Healthcare and Family Services. All services billed were provided by nurses with a valid Illinois license or home health aide certified by the State of Illinois. Verification of services billed must be documented through the time sheets and nursing notes which must be maintained by your Agency for review upon request.

Signature \_\_\_\_\_

Date \_\_\_\_\_

13. TOTAL CHARGES

14. TOTAL DEDUCTIONS

**SEE REVERSE SIDE FOR INSTRUCTIONS**

**PLEASE FORWARD ALL BILLINGS, INSURANCE CARRIER'S EXPLANATION OF BENEFITS AND QUESTIONS TO:**

University of Illinois at Chicago,  
 Division of Specialized Care for Children  
 Claims Services Unit  
 3135 Old Jacksonville Road  
 Springfield, Illinois 62704-6488

Toll Free (877) 791-5170  
 Fax (217) 558-0773  
 Springfield Area (217) 558-2350  
 TTY (217) 785-4728

**“WEEKLY BILLING FOR HOME NURSING” INSTRUCTIONS:**

Please type or print all claims. More than one billing form may be required to submit all charges for the standard billing week.

1. **Provider Name:** Enter the provider's name exactly as it appears on the HFS Provider Information Sheet.
2. **Provider Number:** Enter the twelve digit Provider Key Number exactly as it appears on HFS Provider Information Sheet.
3. **Provider Invoice No.:** Enter up to ten numbers or letters used in your billing system for claim identification. If this field is completed it will print on UIC-DSCC's Provider Explanation of Benefits.
4. **Provider Billing Address:** Enter the billing street address for the agency. (This is the address where payment will be sent.)
5. **City, State, Zip:** Enter city, state and zip code of "Provider Billing Address" above.
6. **Child's Name (First, MI, Last):** Enter the child's name for services being billed.
7. **Provider Site Address (City, State, Zip):** Enter site address, city, state and zip code where the Provider is located.
8. **Prior Approval:** Leave blank.
9. **Recipient Number:** Enter the nine digit HFS recipient number assigned to the child. Use no punctuation or spaces.
10. **UIC-DSCC Number:** Enter the six digit UIC-DSCC case number assigned to the child.
11. **Birth date:** Enter the child's month, day and year of birth. Use the MMDDYY format.
12. **Service Sections:**  
Procedure Description – Enter description of the service performed.  
Procedure Code – Enter the five-digit procedure code for service being billed.  
Modifiers – Enter the appropriate alpha code to identify the type of nursing hours for respite or training hours.  
Date of Service – Enter the date the service was performed. Use MMDDYY format.  
Units/Qty – Enter the total number of 15-minute units worked per day. Combined units of all nursing levels (RN, LPN, HHA) cannot exceed 96 units per day.  
Insurance Amt – Enter the amount paid by insurance for date of service as indicated on insurance carrier's EOB. Insurance carrier EOB must be attached.  
Provider Charge – Enter the total charge for individual date of service. Do not deduct any insurance payments in this area.  
Repeat Box: Enter "X" to repeat information. The repeat indicator may be used to minimize repeated information in the Service Sections. The date of service must be entered in every service section.
13. **Total Charges:** Enter the total charge for each page of the billing form.
14. **Total Deductions:** Enter total insurance benefits paid applicable to the billing period. Insurance carrier EOB must be attached.
15. **Certification:** Signature of person certifying the billing form and date signed.

**PROCEDURES CODES:**

HCPC CODE	MODIFIER	DESCRIPTION	UNITS/MAX UNITS
T1002		Regular RN	15 minute each unit / max 96 units per day
T1003		Regular LPN	15 minute each unit / max 96 units per day
T1004		Regular HHA	15 minute each unit / max 96 units per day
T1005	TD	Respite RN	15 minute each unit / max 96 units per day
T1005	TE	Respite LPN	15 minute each unit / max 96 units per day
S5150		Respite HHA	15 minute each unit / max 96 units per day
S5116	TD	Training RN	15 minute each unit / max 96 units per day
S5116	TE	Training LPN	15 minute each unit / max 96 units per day
T2027		School Hours	15 minute each unit / max 96 units per day