

471-000-127 Explanation of Deleted Medicaid Claims Weekly Report (MCP564-D)

The "Deleted Medicaid Claims" report (MCP564-D) lists paper claims deleted from the Medicaid claims processing system. The report is mailed weekly to all providers who have paper CMS1500, dental and nursing facility claims that were deleted the previous week.

Claims are deleted from the claim processing system because certain requirements prevent adjudication to final paid/denied status. The reason for the deletion is listed on the report. A new, corrected claim must be submitted, if appropriate. If the deleted claim had attachment(s), the attachments must be included with the new claim.

Deleted claims are listed alphabetically by Medicaid client last name. If the Medicaid Client ID Number on the deleted claim is incorrect, the claim is listed on the report under "Unknown." If the Medicaid Provider Number on the deleted claim is incorrect, the claim does not appear on the report; a notice will be mailed to the address on the claim.

Following is an example of the report with descriptions of key fields:

Key Field Descriptions:

1. Report Identifier 'D' indicates that this report lists deleted paper claims.
2. Submitted Amount.
3. National Health Care Claim Status Codes.
4. Total Submitted Amount.
5. Indicates current envelope number and total number of envelopes for this provider number.
6. Medicaid Provider Number and Federal Tax Identification Number.
7. Provider Name and 'Pay to' Address.
8. Indicates this report is continued from a previous envelope.
9. Report Title.
10. Column Heading Information.
11. Medicaid Patient Last Name, First Name, Middle Initial.
12. Medicaid Recipient Number.
13. Date Claim Received.
14. Bill Type.
15. Provider Patient Account Number.
16. Medicaid Claim Number.
17. Service FROM and TO Dates.
18. Medicaid Delete Reason Codes and Descriptions.
19. Total Number of Claims Deleted.
20. Claim Indicates this report is continued in additional envelopes.

XXXXXXXXX XXXXXX
MCP564-D
HH:MM PM MM/DD/CCYY
ENVELOPE X OF X
STATE OF NEBRASKA
HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT
REPORT PAGE 999,999
PROV PAGE 999,999

STATE OF NEBRASKA CONTACT INFORMATION: MEDICAID INQUIRY
(402)471-9128
(877)255-3092

FOR PROVIDER NUMBER: XXXXXXXX-XX FTIN: XXXXXXXX

PROVIDER BUSINESS NAMEXXXXXXXXXXXXX
PROVIDER PAY-TO NAMEXXXXXXXXXXXXX
ADDRESS1XXXXXXXXXXXXX
ADDRESS2XXXXXXXXXXXXX
CITYXXXXXXXXXXXXX XX 99999-9999

REPORT CONTINUED FROM ENVELOPE # X

DELETED MEDICAID CLAIMS
WEEKLY REPORT
* THE CLAIMS LISTED BELOW HAVE BEEN DELETED FROM THE NEBRASKA MEDICAID CLAIMS PROCESSING SYSTEM.
* THESE CLAIMS ARE NO LONGER BEING PROCESSED. THE REASON FOR DELETION OF EACH CLAIM IS PROVIDED
* REVIEW THE DELETION REASONS AND RESUBMIT A NEW CLAIM, IF APPROPRIATE. ALL REQUIRED DOCUMENTA-
* TION MUST BE SUBMITTED WITH THE NEW CLAIM.
RECIPIENT NAME RECIPIENT NBR DATE RECD TYPE BT ACCT NBR CLAIM NBR
SVC FROM SVC TO SUBMITTED AMT 508 REASON CODES
DELETE REASON

LASTNAMEXXXXXXXXXXXXX FIRSTNAMEX M 999999999999 MM/DD/YYYY XXX PACTNUMXXXXXXXXXXXXX 00999999999
MM/DD/YYYY MM/DD/YYYY 9,999,999.99 XXXX XXXX XXXX
XX - DELETE REASON DESCRIPTIONXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XX - DELETE REASON DESCRIPTIONXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XX - DELETE REASON DESCRIPTIONXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TOTAL CLAIMS DELETED: 999,999 TOTAL SUBMITTED AMOUNT: 9,999,999,999.99
*****END OF REPORT*****

