
ATTACHMENT J.19

INSTRUCTIONS TO COMPLETE 719A FORM

INSTRUCTIONS FOR HOW TO COMPLETE A 719A FORM

Field Number	Field Description	Explanation
Upper right hand corner	<ul style="list-style-type: none"> • Red six (6) digit ACS tracking number 	
	<ul style="list-style-type: none"> • Billing Provider 	This is the name of the provider (facility or physician) that will be submitting the claim
	<ul style="list-style-type: none"> • Provider Number 	This is the provider's nine (9) digit number issued by ACS
1A	Recipient DC ID Number	Recipients eight (8) digit Medicaid number
1B	Recipient's Name (Last, First, M.I.)	Include any recent name change
1C	Recipient's Address	Include city, state and zip code
1D	Recipient's Telephone Number	Include area code
2A	Provider Number	This is the requesting provider's nine (9) digit number issued by ACS
2B	Requesting Provider's Name	This is the name of the provider (facility or physician) requesting the service
2C	Recipient's Address	Include city, state and zip code
2D	Recipient's Telephone Number	Include area code
3	Other Health Insurance Coverage	I.e.; Medicare, Kaiser. If no other insurance, "none or N/A" should appear
4	Requested Service	Check one only <ul style="list-style-type: none"> • Surgery • Medical (includes diagnostic tests and pharmaceuticals) • Dental • Medical supplies or equipment • Transportation • Eyewear • Other
5	Patient Location	Check one only <ul style="list-style-type: none"> • Home • ICF/MR • Nursing Home • Hospital inpatient Include discharge date if known.
6	Diagnosis Code	ICD – 9 code that will be submitted on claim
7	Procedure Code	CPT or HCPCS code that will be submitted on the claim
8	Description of Services, Durable medical equipment or supplies	Description must be consistent with CPT or HCPCS code selected
9	Time Required	Length of time equipment or supplies is needed (# of days or months)
10	Frequency or Units	Number of units must be provided for each procedure code submitted.
11	Estimated Charge(s)	The estimated amount for the service/equipment must be provided for each procedure code submitted.
12	Approved Amount(s)	Leave blank
13	Justification	A statement explaining the medical necessity for the requested procedure, service, or equipment. A diagnosis code is not acceptable for justification. Clinical documentation must accompany this form.
14	For Dental Use Only	<ul style="list-style-type: none"> • X = Denote teeth already missing • I = To be extracted • V = X-rays taken
15A	Signature of Requesting Provider	Signature must match the name provided in filed # 2B.
15B	Date	mm/dd/yyyy