

# NJ FamilyCare Housing Supports Program: **Billing Best Practices and the CMS 1500**

September 3, 2025



# Housekeeping

- Please drop your name, organization and role into the chat
- Use the Raise Hand function and we will invite you to come off mute during Q&A

**Regional Health Hubs (RHHs) play an important role supporting DMAHS in key initiatives such as the NJ FamilyCare Housing Supports Program.**

**Camden Coalition will:**

- Deliver and curate a training series to support program roll-out
- Serve as a “help line” for providers to field/answer questions and troubleshoot issues through the process
- Liaise between the state, MCOs, and providers to support implementation

**All RHHs will:**

- Promote the program to recruit a robust network of providers within their regions
- Conduct member/community engagement to inform successful roll-out



## Disclaimer

The views, opinions and content expressed herein do not necessarily reflect the official position of the state of NJ's Department of Community Affairs or Division of Medical Assistance Healthcare Services (DMAHS)



# Objectives

- Review key steps to take before billing
- Provide an overview of the billing process
- Provide field-by-field guidance on how to complete the CMS 1500 claims form for tenancy services
- Summarize key MCO-specific information for easy reference

# Today's Training

- In June, we covered the high level basics of billing, including:
  - Steps to take before you bill
  - High level requirements around HMIS documentation
  - Assessing whether required touchpoints had been met
  - Example timelines for authorization and billing
- In August, we did a deep dive into assessments and authorization scenarios to further build the foundation of these critical steps
- **Today we will cover the mechanics of billing and provide more detail on the specific fields found within the CMS 1500, the claims form required for the Housing Supports program**
- We will walk through a typical “best case scenario” for billing for pre-tenancy and tenancy-sustaining services
- We will also provide a billing “cheat sheet” following this training

# Key Reminders About Billing

- **For pre-tenancy and tenancy-sustaining services:**
  - Billing periods are measured in 30-day increments – and not tied to the calendar month.
  - Providers receive different pay rates for high-needs and low-needs members per the Level of Need assessment.
  - Providers submit claims directly to the member's MCO to get paid.
- **For move-in supports and home mods/remediations:**
  - In general, providers submit a list of their expenses and receive cost-based reimbursements up to a lifetime cap of \$10,000 and \$15,000 respectively.
  - Providers submit a claim directly to the member's MCO to get paid.



Before You Bill

# MCO Provider Portals

## Getting registered for MCO portals

- You will need to be contracted and credentialed before you can get access to MCO portals\*
- Portals are linked below

	Aetna Better Health NJ	Fidelis	Horizon	United	Wellpoint
Online Provider Portal	<a href="#"><u>Aetna Availity portal</u></a>	<a href="#"><u>Fidelis Care Portal</u></a>	<a href="#"><u>Horizon Availity Portal</u></a>	<a href="#"><u>United portal</u></a>	<a href="#"><u>Wellpoint Availity Portal</u></a> Availity Client Services at 800-AVAILITY (800-282-4548) or email support@Availity.com.

\*Note: you can also submit claims manually or through EDI – more info in upcoming slides.

# Setting up electronic payment

	Aetna	Fidelis	Horizon	United	Wellpoint
3 <sup>rd</sup> party payment managers/vendors	<b><u>Echo</u></b>	<b><u>Payspan Health</u></b>	<b><u>Availity Essentials</u></b>	<b><u>Optum Pay®</u></b> , <a href="#">open_in_new</a> with 2 options: <ul style="list-style-type: none"> <li>Automated Clearing House (ACH)/direct deposit</li> <li>Virtual card payments (VCP)</li> </ul> Link to <a href="#">additional information</a> on each payment method	<b><u>EnrollSafe</u></b>
How to enroll	Enroll via <a href="#">Aetna Better Health ECHO portal</a> to sign up for free electronic payments.  Providers can also contact Echo directly by phone at <a href="tel:888-834-3511">888-834-3511</a> or via email at <a href="mailto:allpayer@echohealthinc.com">allpayer@echohealthinc.com</a>	Register for EFT through <b><u>Payspan Health</u></b>	To access EFT registration, please log in to <b><u>Availity Essentials</u></b> : Availity Essentials: opens a dialog window Click on Payer Spaces in the top tool bar and select Horizon NJ Health Under Applications, select EFT Registration	<b>Automated Clearing House (ACH)/direct deposit</b> also known as electronic funds transfer (EFT). See our <b><u>enrollment guide open_in_new</u></b>  <b>Virtual card payments (VCP)</b> A virtual card is issued for each payment and transactions are processed as credits through the same terminal used for patient copays. See our <b><u>user guide open_in_new</u></b>	Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment reducing administrative processes. Use <b><u>EnrollSafe</u></b> to register and manage EFT account changes

# Before submitting a claim, refer to this checklist:

## Billing Pre-Submission Checklist:

Make sure you have the following covered before beginning your claim submission process.

- Member information ready (e.g., address, DOB, policy #)**
- Prior authorization confirmation which should include:**
  - Reference number
  - Treatment date range (*confirm it aligns with the billing period for which you are completing a claim*)
  - # of units authorized (# of months for tenancy services)
  - Type of authorization (service type, low/high)
  - Diagnosis code (whatever you submitted on the auth form)
- Completion of required touchpoints**
  - High needs: minimum of 4 touchpoints; at least 2 in-person
  - Low needs: minimum of 2 touchpoints; at least 1 in-person
- 30-day billing period criteria met**
  - Check that the 30-day billing period is complete
  - Confirm that the touchpoints occurred within the billing period
- Appropriate procedure codes and diagnosis codes identified**
  - HCPCS or procedure code (indicates the service type)
  - Modifier appended to HCPCS code (indicates high or low level of need)
  - Diagnosis or ICD-10 code (Z-code)
- Touchpoints Entered into HMIS**
  - Touchpoints must be entered into HMIS within 5 days of interacting with the member
  - If touchpoints are not logged in HMIS, providers may be subject to penalties or potential claims denials

## Additional Best Practices:

- Make sure the authorization form accurately reflects what you plan to bill for (eg: modifiers)
- You may decide to re-verify the member's insurance status



# Overview of the Billing Process

# Claims Submission

- Providers will use the **CMS 1500** claim form to submit all claims for all four Housing Supports Program services.
- Claims can be submitted electronically or on paper; **electronic is preferred.**
  - Paper claims must be sent through the US mail (not fax or email).
- You can submit claims electronically through the MCO provider portals or by setting up Electronic Data Interchange (**EDI**) through a Clearinghouse.
  - EDI is available to providers who have an electronic medical/health record (EMR or EHR) platform with billing functionality.

# Steps in the Billing Process

1. Receive authorization for the billing period
2. Deliver services
3. Complete claims form (on paper, through portal or through EDI)
4. Submit claim
5. Check the status of a claim
6. Get paid, **or**
7. If denied, work the denial by resubmitting the claim **or** begin the appeals process

# MCO Contact Sheet: Submitting & Checking Claims

	Aetna Better Health NJ	Fidelis	Horizon	United	Wellpoint
Online Portal	<a href="#">Aetna Availity portal</a>	<a href="#">Fidelis Care Portal</a>	<a href="#">Horizon Availity Portal</a>	EDI through any Clearinghouse using <b>*Payer ID: 86047</b>	<a href="#">Wellpoint Availity Portal</a> Availity Client Services at 800-AVAILITY (800-282-4548) or email support@Availity.com.
Checking claim status	Provider Services: <b>855-232-3596 (TTY:711)</b> or check the Availity Portal	Provider Services: <b>888-453-2534</b> For inquires related to electronic submissions, please contact our EDI team at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>	Provider Services: <b>800-682-9091</b> or check the Availity portal online.	Provider services: <b>888-362-3368</b> or check the UHC Provide portal.	Provider Services: <b>833-731-2149</b> or check the Availity portal.
Mail (for manual claims)	Aetna Better Health® of New Jersey Claims and Resubmissions PO Box 982967 El Paso, TX 79998 <b>*Payer ID: 46320</b>	Fidelis Care Claims Department P.O. Box 31224 Tampa, FL 33631-3224	Horizon NJ Health Claims Processing Department PO Box 24078 Newark, NJ 07101-0406	UnitedHealthcare Community Plan P.O. Box 5250 Kingston, NY 12402-5250	Wellpoint NJ Claims P.O. Box 61010 Virginia Beach, VA 23466-1010
Provider forms, resources and trainings	<ul style="list-style-type: none"> <li><a href="#">Aetna Provider Manual</a></li> <li><a href="#">Aetna Provider Website</a></li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Fidelis Care Website</a></li> <li><a href="#">Portal Training</a></li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Horizon Provider Manual</a></li> </ul>	<ul style="list-style-type: none"> <li><a href="#">United Quick Reference Guide</a></li> <li><a href="#">United Housing Training tool</a></li> <li><a href="#">United Care Provider Manual</a></li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Wellpoint Provider Manual</a></li> <li><a href="#">Wellpoint Quick Reference Guide</a></li> </ul>



Completing the **CMS 1500** for  
Pre-tenancy or Tenancy-  
sustaining services

# Billing Guidance

**We'll walk through the CMS 1500 field by field so that you have this deck as a reference, but we will also post:**

- a billing cheat sheet with the critical take-aways**
- a narrative guidance document that also goes field by field.**

## How the billing guidance works


- The guidance in the following slides was developed through a rigorous process of working with each MCO to determine their field-level requirements
- That information was synthesized into a single best practice document that will help ensure your claim meets the standards of all 5 MCOs, rather than having to learn all of the differences between them
  - That is, the guidance will instruct you to consistently fill out all fields that are mandatory for at least one MCO

# Billing Scenario:

## Pre-tenancy Services for the first 30 days

- Jane Doe is a client at Horizon House, an HSP provider, and the provider is submitting a claim to her MCO for the first 30-day billing period.
- Jane Doe is a 25-year-old female experiencing homelessness who currently stays at a local women's shelter. She is receiving Pre-tenancy services from Horizon House as a high level of need member. Horizon House has completed the required touchpoints and is ready to bill her MCO for the services provided.

Open the  
 CMS 1500  
 form [here](#)  
 and follow  
 along



**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA    PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medical#)		TRICARE <input type="checkbox"/> (TRICARE#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)												
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)											
CITY				STATE				8. RESERVED FOR NUCC USE				CITY				STATE							
ZIP CODE				TELEPHONE (Include Area Code)				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)				11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				b. RESERVED FOR NUCC USE				c. RESERVED FOR NUCC USE				d. INSURANCE PLAN NAME OR PROGRAM NAME				12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d</i>							
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED _____ DATE _____												SIGNED _____ DATE _____											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY						15. OTHER DATE QUAL _____ MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
17b. NPI _____						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						23. PRIOR AUTHORIZATION NUMBER _____					
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. ICD-9-CM CODE		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. SPECIAL REF		I. ID. QUAL		J. RENDERING PROVIDER ID. #					
1																							
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER				SGN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov't plans, see 24f) YES NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH# ( )											
SIGNED _____ DATE _____						a. _____ b. _____						c. NPI d. _____											

CARRIER

PATIENT AND INSURED INFORMATION

DIVISION OR SUBDIVISION INFORMATION

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) Q2/12

PICA  
 1. MEDICARE  (Medicare#)   
 MEDICAID  (Medicaid#)   
 TRICARE  (ID#/DcD#)   
 CHAMPVA  (Member ID#)   
 GROUP HEALTH PLAN  (ID#)   
 FECA BLK LUNG  (ID#)   
 OTHER  (ID#)

1 a. INSURED'S I.D. NUMBER (For Program in Item 1)

XYZ

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Doe, Jane

3. PATIENT'S BIRTH DATE (MM | DD | YY) SEX

01 | 01 | 2000    M     F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Doe, Jane

**Note:** “Patient” and “Insured” mean the same thing throughout this form – they both refer to the Medicaid member. (There is a lot of redundancy in this form!)

Field	Provider guidelines
1: Type of insurance	Mark 'Medicaid' only.
1A: Insured's ID Number	Enter the member's ID number as shown on the member's MCO ID card. Please note that Wellpoint may label Medicaid ID as "Subscriber #" on the member's ID card.  The ID should reflect the member's ID with the MCO, which might be different than their state-issued Medicaid ID.
2: Patient name	Enter the member's full last name, first name, and middle initial separated by commas (e.g., Doe, John, S).  Do not include periods, credentials (e.g., PhD, Dr), or nicknames.
3: Patient DOB, sex	Enter the member's 8-digit birth date (MM   DD   YY) and enter an 'X' in one box to indicate sex of the member.  Note: DOB is important to input accurately, as it may be used to identify the member in MCOs' data to ensure a match.
4: Insured's name	Enter the member's full last name, first name, and middle initial (This should be the same as field 2).

5. PATIENT'S ADDRESS (No., Street)	
777 Place St	
CITY	STATE
Camden	NJ
ZIP CODE	TELEPHONE (Include Area Code)
08105	( 555 ) 1234567

6. PATIENT RELATIONSHIP TO INSURED							
Self	<input checked="" type="checkbox"/>	Spouse	<input type="checkbox"/>	Child	<input type="checkbox"/>	Other	<input type="checkbox"/>

7. INSURED'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)
	( )

**Note:** “Patient” and “Insured” mean the same thing throughout this form – they both refer to the Medicaid member. (There is a lot of redundancy in this form!)

<b>5: Patient address</b>	<p>Enter the member's complete address; the first line is street address (incl. unit number, if applicable), the second line is city and state, and the third line should include a 5-digit zip code. Telephone may be left blank.</p> <p>Do not include punctuation in the address (e.g., Apt 107 instead of Apt. #107)</p> <p>If member does not have a stable address, may input the address listed for the member's Medicaid enrollment or shelter address.</p>
<b>6: Patient relationship to insured</b>	<p>Mark 'X' in 'Self' only.</p>
<b>7: Insured's address</b>	<p>Leave blank</p>

CITY <b>Camden</b>		STATE <b>NJ</b>	8. RESERVED FOR NUCC USE
ZIP CODE <b>08105</b>	TELEPHONE (Include Area Code) <b>( 555 ) 1234567</b>		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:  a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/>  c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
a. OTHER INSURED'S POLICY OR GROUP NUMBER			
b. RESERVED FOR NUCC USE			
c. RESERVED FOR NUCC USE			
d. INSURANCE PLAN NAME OR PROGRAM NAME			

11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. INSURED'S DATE OF BIRTH			
MM	DD	YY	SEX
<b>01</b>	<b>01</b>	<b>2000</b>	M <input type="checkbox"/> F <input checked="" type="checkbox"/>
b. OTHER CLAIM ID (Designated by NUCC)			
c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Horizon NJ Health</b>			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			

**8: Reserved for NUCC use**

Leave blank.

**9: Other Insured's name**

This field should be filled in only if marking 'X' for "Yes" in 11D (i.e., member has another insurance coverage). If so, must include name (full last name, first name, and middle initial) of other insurance holder.

**9A: Other Insured's policy / group number**

This field should be filled in only if marking 'X' for "Yes" in 11D (i.e., member has another insurance coverage). If so, must include policy or group number of other insurance.

**9B: Reserved for NUCC use**

Leave blank.

**9C: Reserved for NUCC use**

Leave blank.

**9D: Insurance Plan Name or Program Name**

This field should be filled in only if marking 'X' for "Yes" in 11D. If member has another insurance coverage to include, must enter name of other plan or program.

**10A: Is patient's condition related to employment?**

Check off Yes or No. Likely to mark no - only mark yes if the service is directly related to a work-place accident.

**10B: Is patient's condition related to auto accident?**

Check off Yes or No. Likely to mark no - only mark yes if the service is directly related to an auto accident

**10C: Is patient's condition related to other accident?**

Check off Yes or No. Likely to mark no - only mark yes if the service is related to an accident other than an auto accident

**10D: Claim codes (designated by NUCC)**

Leave blank.

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM   DD   YY      M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?      PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
SIGNED _____ DATE _____				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
				SIGNED <u>Signature on File</u>	

PATIENT AND INSURED INFO

<b>11: Insured's policy group or FECA number</b>	Leave blank.
<b>11A: Insured's DOB, sex</b>	Same as Box 3. Enter the member's 8-digit birth date (MM   DD   YY) and enter an 'X' in one box to indicate sex of the member.
<b>11B: Insured's other claim ID (designated by NUCC)</b>	Leave blank.
<b>11C: Insured's insurance plan / program name</b>	Input name of insurance associated with member's MCO, e.g.: - Aetna Better Health of NJ - Fidelis Care (for Medicaid/Core Caid); Wellcare for FIDE-SNP - Horizon NJ Health - UHC Community Plan of NJ or United HealthCare Community Plan or NJ FAMCAR or NJ DUALCM - Wellpoint NJ
<b>11D: Insured - is there another health benefit plan</b>	Check 'Yes' or 'No' to indicate if there is another health benefit plan for the member; if yes, must complete 9, 9A, 9D.
<b>12: Patient or authorized person's signature</b>	Leave blank.
<b>13: Insured's or authorized person's signature</b>	Enter 'Signature on File' ('SOF'). Provider should ensure that they have the signature of the member on file.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) <small>MM DD YY</small> QUAL.	15. OTHER DATE <small>MM DD YY</small> QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION <small>MM DD YY</small> FROM <small>MM DD YY</small> TO <small>MM DD YY</small>
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <small>MM DD YY</small> FROM <small>MM DD YY</small> TO <small>MM DD YY</small>

<b>14: Date of current illness, injury, or pregnancy</b>	Leave blank.
<b>15: Other date</b>	Leave blank.
<b>16: Dates patient unable to work in current occupation</b>	Leave blank.
<b>17: Name of referring provider or other source</b>	Leave blank.
<b>17A: Referring provider - other ID</b>	Leave blank.
<b>17B: Referring provider NPI</b>	Leave blank.
<b>18: Hospitalization dates related to current services</b>	Leave blank.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NJCC)				20. OUTSIDE LAB? \$CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. Z59.01 B. C. ICD Ind. 0 E. F. G. H. I. J. K. L.				22. RESUBMISSION CODE ORIGINAL REF. NO. 1	
				23. PRIOR AUTHORIZATION NUMBER 123456	

**19: Additional claim information (designated by NJCC)**

Leave blank

**20: Outside lab information**

Leave blank

**21: Diagnosis or nature of illness or injury**

Use this field to enter the diagnosis code associated with the claim. Some MCOs will deny a claim if the code listed on the authorization form does not match the code on the claim form. We recommend cross-checking codes between forms before submitting claims.

In the "ICD Ind." field, enter 0 if you are entering an ICD-10 code. However, if using an ICD-9-CM code, use 9 as the indicator in the first field. Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field. Most likely to enter 0 since ICD-9 codes are legacy codes. Typically, ICD-10 codes are alphanumeric and are up to 7 characters, while ICD-9 codes are 3-5 characters in length and are typically numeric. If unsure if the code is ICD-10 or ICD-9, recommend checking through CMS website.

Enter the applicable diagnosis codes starting in the field marked 'A'. You may enter up to 12 codes (one code for A-L). However, we expect that only one diagnosis code is necessary. The remaining lines (B-L) may be left blank, assuming no other additional diagnosis codes apply.

See Housing Supports provider guidance for applicable situations and associated ICD-10 codes. Providers may interpret ICD-10 codes for this field as Z codes, which are a type of ICD 10 code used to define health related social needs. For example, the ICD-10 code for sheltered homelessness is Z59.01. Please note that MCOs may authorize services under the generic ICD-10 code (Z00.00). Again, best practice to cross-reference the code on the authorization form with the claim form.

**22: Resubmission code**

Enter the appropriate bill frequency code:

- 1: Initial submission
- 7: Replacement of prior claim
- 8: Void/cancel of prior claim

Include the original reference number if associated with previously submitted claim. For example, if coding as #7, the provider should include the original claim number from the first claim submission under "original ref. no."

**23: Prior authorization number**

Include prior authorization number authorizing the service this claim is for; providers typically may find this number on their authorization approval letter and/or in the MCO's provider portal.

Not all MCOs require this number on the claims form, but it is recommended to include as a best practice.

1  
0

24. A.	DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMG
	From				To		
MM	DD	YY	MM	DD	YY		
09	01	25	09	30	25	04	

**24B. Place of Service Codes:** DMAHS expects Housing Supports providers to use one of the first four codes most frequently. If provider is unsure of which code to select, they may use code 99. Fidelis will only accept one of these five codes while other MCOs will accept any valid CMS code that accurately captures the place of service.

<b>04</b> Homeless Shelter	<b>12</b> Home	<b>16</b> Temporary lodging	<b>27</b> Outreach site/street	<b>99</b> If place of service is not captured
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**24A: Date(s) of service**

Best practice is to input dates of the full 30-day billing period, associated with the relevant billing period under members' authorization. Use format MM | DD | YY. For example:

- "From": 1st day of billing period (e.g., 01 | 01 | 26)
- "To": last day of billing period (e.g., 01 | 30 | 26)

Note that providers may only be paid 1x per billing period and should submit 1 claim per 30-day billing period (i.e., do not submit a claim each time a touchpoint is made).

If billing for multiple 30-day billing periods, list each 30-day billing period in separate lines.

Note: some MCOs may accept date ranges less than but within the 30-day billing period.

**24B: Place of service**

Enter a valid place of service code (POS), as identified by CMS. Please reference CMS' [list](#) of valid codes. Please enter the code that most closely captures where services were rendered throughout the month. If services were rendered in multiple locations, may also enter 99 (Other place of service). As a reminder, at least half of member touchpoints must be in person.

We expect the following five codes to be the common POS codes for providers to enter, which all MCOs accept: 04 (Homeless shelter); 12 (Home); 16 (Temporary lodging); 27 (Outreach site/street); 99 (Other place of service).

Some MCOs may deny a claim if the Place of Service code indicates a member is ineligible for services (e.g., 09 may indicate a member is in prison). Still recommend entering the code that accurately captures where services were rendered and, if denied, connecting with your MCO to understand reasons for denial.

If unsure on location even after reviewing all valid CMS options, may enter POS 99.

**24C: Emergency indicator**

Leave blank

19. ADDITIONAL CLAIM INFORMATION (Designated by NCCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 1r

A. Z59.01	B.	C.
E.	F.	G.
I.	J.	K.

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS
	From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER				
1	09	01	25	09	30	25	04		H0044	U3		A	640.00	1

**24D: Procedure code**

Enter 'H0044' (Tenancy Services) and modifier (indicating Pre-tenancy Services vs. Tenancy Sustaining Services and Level of Need), as listed on the prior authorization.

Modifiers for tenancy-related services include:

U1: Lower level of need for pre-tenancy services

U3: Higher level of need for pre-tenancy services

U4: Lower level of need for tenancy-sustaining services

U6: Higher level of need for tenancy-sustaining services

As a reminder, if a member is authorized for a higher level of need but the provider is only able to deliver 2-3 touchpoints in a given billing cycle, the provider may bill for the lower level of need rate. If this scenario applies to you, enter the modifier associated with the lower level of need in this field. The procedure code on the authorization form will not match your entry on this form as a result. Recommend connecting with your MCO to ensure successful claims submission in this circumstance.

**24E: Diagnosis pointer**

Field 24E links the diagnosis code(s) in Field 21 to the specific service line being billed. If the diagnosis code in Field 21 is listed under "A", the provider should enter "A" in Field 24E. If the code is in Field B, enter "B"; if in Field C, enter "C"; and so forth. At least one diagnosis reference (A, B, C, or D – sometimes displayed as 1, 2, 3, 4 in online portals) must be included. Multiple letters can be entered if the service line relates to more than one diagnosis, but most likely only one entry is necessary.

**24F: Charges**

Provider should indicate charge equal to state-defined rate of procedure code. Note: MCOs may only pay up to the billed amount (the amount requested on the claim) if billed for a lower value than the state-defined rate.

Do not include dollar sign or negative amounts; enter "00" in cents area if amount is a whole number.

**24G: Days or units**

Enter 1 (1 unit = one 30-day billing period), regardless of number of touchpoints made. Note: provider should only submit claim if minimum required touchpoints were made.

If billing for multiple 30-day billing periods, list each 30-day billing period in separate lines, with 1 unit per 30-day billing unit.

# Billing Code Cheat Sheet

Billing Codes				
Service Type	Description	24D. HCPCS/Procedure Codes	24D. Modifier	21. Recommended diagnosis or Z-codes (ICD-10)
<b>Pre-tenancy</b>	Housing case management – before stable housing	H0044	U1: low need U3: high need	<b>Generic ICD-10 Code</b> Z00.00 <b>Homelessness:</b> Z59.01 (Sheltered) Z59.02 (Unsheltered) <b>At Risk of Homelessness</b> Z59.811 (unstably housed) Z59.2 (discord with neighbors/landlord) <b>Inadequate Housing</b> Z59.10 (unspecified) Z59.11 (temperature) Z59.12 (utilities) Z69.19 (other inadequate housing)
<b>Tenancy-sustaining</b>	Housing case management – maintaining stable housing	H0044	U4: low need U6: high need	
<b>Move-in supports</b>	One-time housing transition costs	T2038	U1: standard move-in U6: move-in admin fee	
<b>Home Modifications &amp; Remediation: Evaluation</b>	Evaluation for remediation/mods	T1028	None	
<b>Home Modifications &amp; Remediations: Cost-based Reimbursement</b>	Installation of home modifications or remediation services	S5165	U2: home mods U3: environmental remediation	

H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	INFORMATION
	ZZ	251B00000X	
	NPI	8400000025	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN
10-0000025	<input type="checkbox"/>	<input checked="" type="checkbox"/>

<b>24H: EPSDT family plan</b>	Leave blank
<b>24I: ID qualifier</b>	<p>If MCO is Aetna, Fidelis, UHC, or Horizon: Enter 'ZZ'. The 'ZZ' code indicates a rendering provider taxonomy qualifier.</p> <p>The ZZ code informs the MCO of the kind of information the provider is entering in follow-up fields. When entering ZZ, it signals that entries in related fields are provider taxonomy codes. Without the "ZZ," MCOs might assume the entry is related to a different category (e.g., state license numbers).</p> <p>If MCO is Wellpoint: Leave blank</p>
<b>24J: Rendering provider ID</b>	<p>If MCO is Aetna, Fidelis, UHC, or Horizon: In shaded area (top), include non-NPI ID number (i.e., taxonomy code associated with NPI). For Pre-tenancy or Tenancy Sustaining services, the taxonomy will be '251B00000X'.</p> <p>In non-shared area, include provider's Type II NPI (the NPI for which the provider is credentialled for). Note that all credentialled Housing Supports Tenancy Services providers must have Type II NPIs.</p> <p>If MCO is Wellpoint: Leave blank</p>
<b>25: Federal Tax ID Number (SSN / EIN)</b>	Provider organization 9-digit tax ID number. Select 'X' for EIN.

26. PATIENT'S ACCOUNT NO. JaDoe01012000	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 640.00
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29. AMOUNT PAID \$	30. Rsvd. for NUCC Use
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
Horizon House	08/26/2025
SIGNED	DATE

<b>26: Patient's account number</b>	Enter a provider-designated unique member identifier. This field is helpful for provider organization's internal tracking.
<b>27: Accept assignment?</b>	Select 'yes' to indicate that the provider agrees to accept assignment under the terms of the Medicaid program.; Only 1 box can be selected.
<b>28: Total charge</b>	Please total up all the charges listed on 24F. Do not include dollar sign or negative amounts; enter "00" in cents area if amount is a whole number.
<b>29: Amount paid (from other coverage)</b>	Leave blank.
<b>30: Reserved for NUCC use</b>	Leave blank.
<b>31: Physician signature and degrees / credentials</b>	If MCO is Aetna, Fidelis, Horizon, or UHC, enter agency's name in this field and do not provide a signature. If MCO is Wellpoint, leave blank.

<b>32. SERVICE FACILITY LOCATION INFORMATION</b>	
a.	NPI
b.	

<b>32: Service facility location information</b>	Some MCOs require, others do not; recommend entering servicing facility address when different from the billing address that is entered in box 33. If the billing address is the same as the service location, box 32 can be left blank.
<b>32A: Service facility location information - NPI #</b>	Some MCOs require, others do not; recommend inputting the NPI number of the service facility location. Can be left blank if the billing facility is the same as the service facility.
<b>32B: Service facility location information - other ID #</b>	Some MCOs require, others do not; recommend entering the qualifier identifying the non-NPI number followed by the ID number (see instructions for 33B). Can be left blank if the billing facility is the same as the service facility.

<b>33. BILLING PROVIDER INFO &amp; PH #</b> ( 555 ) 8675309	
Horizon House 1234 Horizon St Camden, NJ 08102	
<b>a.</b> 8400000025	<b>b.</b> ZZ251B00000X

<p><b>33: Billing provider - name, address, phone number</b></p>	<p>Enter the provider's complete address, including:          Top right corner: Phone number          1st line: Provider Name          2nd line: Street address (incl. unit number, if applicable)          3rd line: City state (2 digit code) and 5-digit zip code          Do not include punctuation or commas in the address (e.g., Apt 107 instead of Apt. #107).          Please use the same address used on the credentialing application.</p>
<p><b>33A: Billing provider info and phone number - NPI #</b></p>	<p>Include provider's Type II NPI (the NPI for which the provider is credentialed for). Note that all credentialed Housing Supports Tenancy Services providers must have Type II NPIs.</p>
<p><b>33B: Billing provider info and phone number - other ID #</b></p>	<p>Enter 'ZZ' and the non-NPI ID number (i.e., taxonomy code associated with NPI). For Pre-tenancy or Tenancy Sustaining services, this box will be 'ZZ251B00000X'          The ZZ code informs the MCO of the kind of information the provider is entering. When entering ZZ, it signals that entries in related fields are provider taxonomy codes. Without the "ZZ," MCOs might assume the entry is related to a different category (e.g., state license numbers).</p>

## Move-in Supports Claims | Guidance slightly varies depending on service type for select fields; we compiled a list of the key distinctions

Field	Tenancy guidance	Move-in supports guidance
Date of service	Input dates of the full 30-day billing period (See Tenancy guidance for full details)	Enter the actual dates of service delivery, within the date range authorized by the MCO  <i>Note: if service extends beyond 30 days, contact the MCO to clarify best practices for claims submission</i>
Procedure code	Enter appropriate Tenancy services procedure code and modifier to indicate level of need	Enter appropriate Move-In Supports procedure code and modifier
Place of service	Enter a valid Place of Service code; likely 04 (Homeless shelter); 12 (Home); 16 (Temporary lodging); 27 (Outreach site/street)	Enter a valid Place of Service code; likely 12 (Home); 16 (Temporary lodging)
Charges	Indicate charge equal to state-defined rate of procedure code	Indicate amount the provider expensed associated with the authorization



More on Billing

# Example Billing Timeline for Pre-Tenancy and Tenancy Sustaining Services

Action	Date	Significance
Meet Mr. Smith for the first time	May 20	
Complete and submit the Initial Assessment Tool for the initial 30-day authorization period	May 26	
Receive approval for the first 30-day authorization period	May 28	
Complete and submit the Level of Need and Housing Stabilization Plan for the continuing 31 to 180 day authorization period	June 5	
Receive approval for the 31 to 180 day authorization period	June 11	Note: Submit your first claim AFTER you receive approval for the 31 to 180 day auth period because the approval confirms the Level of Need and, therefore, the amount you can bill for
	June 24	This is the last day of the first 30-day billing period
<b>You can submit a claim for services rendered between May 26 and June 24</b>	<b>June 25</b>	<b>This is <u>FIRST</u> day you can submit a claim for the first 30-day billing period</b>
<b>You can submit a claim for services rendered between May 26 and June 24</b>	<b>Nov. 21</b>	<b>This is the <u>LAST</u> day you can submit a claim for the first 30-day billing period (180 days from 1<sup>st</sup> day of billing period)</b>

## Recommendations to help ensure the MCO will accept (and not deny) your claim

- 1) Ensure you've received authorization to provide services to the member – that you've got an MCO authorization approval letter.
  
- **2) Enter the exact information from the member's authorization approval letter into the CMS 1500.**
  - Enter the diagnosis code and the modifier from the authorization approval letter into the CMS 1500.
  - Enter the exact dates of service from the authorization approval letter into the CMS 1500. And in most cases the dates will be 30-day periods.
  
- 3) File your claims in a timely manner.
  - First time claims must be submitted within 180 days of service.
  - Corrected claims must be submitted within 365 days of service.

## Recommendations to help ensure the MCO will accept (and not deny) your claim (con't)

- 4) Use the agency address, EIN and NPI# you entered in your credentialing application in the CMS 1500.
- 5) When you submit a corrected CMS 1500 claim, make sure you enter the correct code/number in Field 22.
  - Enter 7 if the MCO said submit a new claim to replace the previous claim (because the previous claim is “pended” or incorrect/unclear).
  - Enter 8 if the MCO canceled or denied a previous claim and now you are resubmitting.
- 6) Double check that you did not previously submit the claim. If you do, the MCO will deny it.

# Contact the MCO for billing and claims assistance - The info below is on the webpage [here](#)

**Claims:** If you need help submitting claims, checking claims status, resolving denied claims, or addressing payment issues:

Aetna	Fidelis	Horizon	United	Wellpoint
Provider Relations: <a href="mailto:NJProviderExperienceMailbox@AETNA.com">NJProviderExperienceMailbox@AETNA.com</a> Telephone: 1-855-232-3596, Press * for Housing Supports Provider	For support with electronic submissions to Fidelis Care: EDIBA@centene.com  General Provider Services Telephone: 1-888-453-2534	Call Housing Supports Provider Services Telephone: 1-833-241-4181	Provider Network Advocate team: nj_hcbs_pr@uhc.com	Provider Relations Department: Telephone: 1-833-731-2149 E-mail: <a href="mailto:NJHousing@wellpoint.com">NJHousing@wellpoint.com</a>

# Next steps

- Upcoming trainings (every other Wednesday from 1 – 2:30 pm):
  - 9/17 – Office Hours
- Bookmark the Housing Supports webpage [here](#)
- Sign up for our Housing Supports Program newsletter [here](#)
- Use our Help Desk Inquiry Form to ask your questions and get timely support [here](#)

