

SECTION II – SUPPORTIVE MATERNAL CARE

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200.000 SUPPORTIVE MATERNAL CARE GENERAL INFORMATION

200.100 Definitions

9-1-26

As used in this manual:

A. “Breastfeeding and lactation consultant” means:

1. An International Board-Certified Lactation Consultant certified by the International Board of Lactation Consultant Examiners;
2. A Certified Breastfeeding Counselor certified by the International Breastfeeding Institute; or
3. A Certified Lactation Counselor certified by the Academy of Lactation Policy and Practice.

A certified breastfeeding counselor or certified lactation counselor as described in subdivisions A.2. and A.3. of this section, must be supervised. “Supervision” means employed by one (1) of the following Arkansas Medicaid-enrolled providers:

- a. An agency led by an International Board-Certified Lactation Consultant;
- b. A physician, advanced practice nurse, or physician assistant;
- c. A local health unit; or

- d. A hospital;
- B. “Breastfeeding and lactation consultant services” means medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the first twelve (12) months of the infant’s life to aid in milk expression or infant nutrition;
- C. “Certified community-based doula” or “doula” means:
 - 1. An individual who is a trained professional and provides nonclinical emotional, physical, and informational support to women before and during pregnancy and continuing through the postpartum period;
 - 2. A doula must be certified as a community-based doula as provided in Arkansas Code § 17-108-201 et seq., and 17 CAR pt. 56; and
- D. “Healthcare professional” means a person who is licensed by the laws of this state to administer health care in the ordinary course of the practice of his or her profession.

200.200 **Arkansas Medicaid Participation Requirements for Supportive Maternal Care Providers** **9-1-26**

- A. All providers must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:
 - 1. Must be at least eighteen (18) years of age;
 - 2. Obtain and maintain a National Provider Identifier;
 - 3. Use the taxonomy number required by the state; and
 - 4. Hold the appropriate certification to provide that service as described in Section 200.100.

200.300 **Group Providers of Supportive Maternal Care Services** **9-1-26**

Group providers of certified community-based doula services, breastfeeding and lactation consultant services, or both, must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a doula or breastfeeding and lactation consultant is a member of a group of providers, each individual provider and the group must enroll according to the following criteria:

- A. Each individual doula or breastfeeding and lactation consultant within the group must enroll following the criteria established in Section 200.200.

The group must complete an application and contract as an Arkansas Medicaid provider of certified community-based doula services, breastfeeding and lactation consultant services, or both, and must be approved by the Arkansas Medicaid Program.
- B. The group must also be enrolled in the Title XVIII (Medicare) program. Out-of-state providers must submit proof of current Medicare enrollment.
- C. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled licensed doula or breastfeeding and lactation consultant within the group.

200.400 **Administrative Reconsideration and Appeals** **9-1-26**

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse action, the beneficiary or the provider may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this manual.

210.000 CERTIFIED COMMUNITY-BASED DOULAS

210.100 Scope

9-1-26

- A. Arkansas Medicaid beneficiaries are eligible for services provided by certified community-based doula if they are:
 - 1. Pregnant or within sixteen (16) weeks postpartum;
 - 2. Not enrolled in a Life 360 Home Program; and
 - 3. Not receiving community health worker (CHW) services from a CHW employed by an obstetric (OB) clinic or provider.
- B. Doula services may be provided upon the confirmation of pregnancy or delivery.
- C. Doula services are available for up to sixteen (16) weeks postpartum, depending on the beneficiary's continued Arkansas Medicaid eligibility.
- D. Certified community-based doula shall provide only the following services:
 - 1. Childbirth education;
 - 2. Assistance with navigating the healthcare system;
 - 3. Beneficiary advocacy before, during, and after the birth of a child;
 - 4. Connection with community resources; and
 - 5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

210.200 Required Recommendation for Preventative Services

9-1-26

Doula services, as preventative services, require a recommendation from an Arkansas Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse, including a certified nurse midwife. DHS has obtained a statewide standing recommendation from a licensed healthcare provider for doula services for all pregnant or postpartum Medicaid beneficiaries. The statewide standing recommendation applies to Medicaid beneficiaries eligible for doula services. Separate documentation regarding the recommendation by doula providers is not required.

210.300 Covered Benefits — Benefit Limits

9-1-26

- A. Doula services for the same beneficiary and pregnancy are limited to the following:
 - 1. Up to six (6) visits during the prenatal and postpartum periods.
 - a. Postpartum visits must occur within sixteen (16) weeks of labor and delivery; and
 - 2. One (1) visit for attendance at labor and delivery.
 - a. A qualifying visit for attendance at labor and delivery requires the doula to be physically present during labor, delivery, and the immediate postpartum period.

- B. The following procedure codes may be billed by doulas:

[View or print the procedure codes for doula services.](#)

- C. A prior authorization is not required to access the standard doula benefit package.

- D. Medicaid beneficiaries are responsible for:

1. Payment for services beyond the established visit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.
2. A request for extension of benefits may be submitted for beneficiaries with extenuating circumstances if there is need for additional visits beyond the six (6) prenatal and postpartum visits. Extension of benefits requests must be sent to the Department of Human Services (DHS)-contracted entity that processes extensions of benefits for beneficiaries.

[View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.](#)

For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors.

3. If a beneficiary elects to receive a service for which DMS has denied a benefit extension, or for which DMS subsequently denies a benefit extension, the patient is responsible for payment.
- E. Doula services are not counted against the limit of sixteen (16) provider visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. The sixteen-visit limit does not apply to beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

210.400 Visit Requirements

9-1-26

- A. The minimum visit length for doula services is sixty (60) minutes.
- B. The initial visit must be in person, and at least one (1) visit must take place in the beneficiary's home.
- C. After the initial visit, subsequent prenatal and postpartum visits may be conducted in person or via telehealth.
- D. Labor and delivery services may not be conducted via telehealth.
- E. The doula will work with the beneficiary to determine how to utilize the visits to best meet the needs of the beneficiary, including how many visits will occur during the prenatal period or postpartum period.
1. For prenatal and postpartum visits, doulas must coordinate directly with the beneficiary to determine the most appropriate service location, including telehealth, for prenatal and postpartum visits.
 2. Service locations may include the following:
 - a. Beneficiary's place of residence;
 - b. Doula's office;
 - c. Physician's office;
 - d. Hospital;
 - e. Homeless shelter;
 - f. Group home;

- g. Temporary lodging;
 - h. Outreach site; or
 - i. Public health clinic.
- F. The labor and delivery care visit may not occur in the beneficiary's residence.

210.500 Documentation Requirements**9-1-26**

- A. In addition to the conditions related to record keeping in Section 142.300, doulas performing services for Arkansas Medicaid beneficiaries must maintain the following documentation for each encounter:
- 1. Date of service;
 - 2. Person or persons to whom services were rendered, including Medicaid ID number;
 - 3. Start time and end time of services provided;
 - 4. Description of the professional services rendered by the doula on behalf of the beneficiary, including results of assessments for health-related social needs and a birth plan;
 - 5. Any new needs identified during the service; and
 - 6. Original or electronic signature of the doula, including the credentials of the doula.
- B. Documentation and claims may be subject to review and post-payment audit.

210.600 Reimbursement**9-1-26**

- A. All doula services outlined in this manual are reimbursed per the methodology established in the Arkansas Medicaid State Plan.
- B. Doulas who are also breastfeeding and lactation consultants may bill for breastfeeding and lactation services separate from the services they provide as doulas for the same beneficiary.
- C. Doulas who are also certified nurse-midwives may not bill for both doula services and midwife services for the same beneficiary for the same pregnancy.
- D. Healthcare professionals employing doulas may bill for services the doulas provide.
- E. Doula services may be billed separately from the hospital per diem for both inpatient and outpatient visits.
- F. Federally qualified health centers and rural health centers may bill for doula services outside the core encounter visit.

220.000 BREASTFEEDING AND LACTATION CONSULTANTS**220.100 Scope****9-1-26**

- A. Only Arkansas Medicaid beneficiaries who are pregnant or within twelve (12) months postpartum and infants up to twelve (12) months of age are eligible for breastfeeding and lactation consultant services.
- B. Breastfeeding and lactation consultant services are available for twelve (12) months postpartum, depending on the beneficiary's continued Arkansas Medicaid eligibility.
- C. Breastfeeding and lactation consultant services include medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant

during pregnancy and through the postpartum period to aid in milk expression or infant nutrition.

220.200 Required Recommendation for Preventative Services**9-1-26**

Breastfeeding and lactation services, as preventative services, require a recommendation from an Arkansas Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse, including a certified nurse midwife. DHS has obtained a statewide standing recommendation from a licensed healthcare provider for breastfeeding and lactation consultant services for all pregnant or postpartum Medicaid beneficiaries. The statewide standing recommendation applies to Medicaid beneficiaries eligible for breastfeeding and lactation consultant services. Separate documentation regarding the recommendation by breastfeeding and lactation consultant providers is not required.

220.300 Covered Benefits — Benefit Limits**9-1-26**

- A. Benefit limits are as follows:
1. Breastfeeding and lactation consultant services for Medicaid beneficiaries who are pregnant or within twelve (12) months postpartum are limited to a maximum of three (3) visits for each pregnancy. No prior authorization is needed for these visits.
 2. Breastfeeding and lactation consultant services for Medicaid beneficiaries who are twelve (12) months or younger are limited to a maximum of three (3) visits. No prior authorization is needed for these visits.
- B. The following procedure codes may be billed by breastfeeding and lactation consultants.

[View or print the procedure codes for breastfeeding and lactation consultant services.](#)

1. Medicaid beneficiaries are responsible for payment for services beyond the established visit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.
2. A request for extension of benefits may be submitted, for beneficiaries with extenuating circumstances, if there is need for additional visits. Extension of benefits requests must be sent to the Department of Human Services (DHS)-contracted entity that processes extensions of benefits for beneficiaries.

[View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.](#)

For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors. Extension of benefits should contain the medical reason for additional services and be signed by the supervising provider.

- C. Group services may be provided but are subject to the limits described in Subsection A of this section. When providing services in a group setting, the number of participants must be at least two (2) participants and no more than eight (8) participants.
- D. Breastfeeding and lactation consultant services are not counted against the limit of sixteen (16) visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. The sixteen-visit limit does not apply to beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

220.400 Visit Requirements**9-1-26**

- A. The minimum visit length for breastfeeding and lactation consultant services is fifteen (15) minutes.

The maximum visit length is ninety (90) minutes.

- B. The initial visit must be in person. After the initial visit, subsequent visits may be conducted in person or via telehealth.
- C. Services provided in a group setting must be in person.
- D. The breastfeeding and lactation consultant will work with the beneficiary or the beneficiary's mother to determine how to utilize the visits to best meet the needs of the beneficiary.
- E. Breastfeeding and lactation consultants must coordinate directly with the beneficiary or the beneficiary's mother to determine the most appropriate service location.
- F. Service locations may include the following:
 - 1. Beneficiary's place of residence;
 - 2. Breastfeeding and lactation consultant's office;
 - 3. Office of supervising physician, advanced practice nurse, or physician assistant;
 - 4. A local health unit or a Women, Infants and Children's office operated by the Arkansas Department of Health; or
 - 5. Hospital.

220.500 Documentation Requirements

9-1-26

- A. In addition to the conditions related to record keeping in Section 142.300, breastfeeding and lactation consultants performing services for Arkansas Medicaid beneficiaries must maintain the following documentation:
 - 1. Date of service;
 - 2. Person or persons to whom services were rendered, including Medicaid ID number;
 - 3. Start time and end time of services provided;
 - 4. Treatment plan, including problems, goals, and objectives, as appropriate, and updates;
 - 5. Method or methods used or to be used to address the identified problems, goals, and objectives;
 - 6. Progress made;
 - 8. Any new problems, goals, or objectives identified during the service; and
 - 9. Original or electronic signature of the breastfeeding and lactation consultant, including the credentials of the breastfeeding and lactation consultant.
- B. Documentation and claims may be subject to review and post-payment audit.

220.600 Reimbursement

9-1-26

- A. All breastfeeding and lactation consultant services outlined in this manual are reimbursed per the methodology established in the Arkansas Medicaid State Plan.
- B. Breastfeeding and lactation consultants who are also doulas may bill for breastfeeding and lactation services separate from the services they provide as doulas for the same beneficiary.
- C. Breastfeeding and lactation consultants who are also community health workers (CHWs) may bill for breastfeeding and lactation services separate from the services they provide as CHWs for the same beneficiary.

- D. Breastfeeding and lactations consultants who are also certified nurse-midwives (CNMs) may bill for breastfeeding and lactation consultant services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.
- E. Healthcare professionals employing breastfeeding and lactation consultants may bill for the services the consultants provide.
- F. During an inpatient hospital stay, breastfeeding and lactation consultant services cannot be billed separately from the hospital per diem. Breastfeeding and lactation consultant services provided in an outpatient hospital setting may be billed separately.
- G. Federally qualified health centers and rural health centers may bill for breastfeeding and lactation consultant services outside the core encounter visit.

230.000 BILLING PROCEDURES

230.100 Introduction to Billing

9-1-26

Douglas and breastfeeding and lactation consultants use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided for eligible Medicaid beneficiaries. Section III of this manual contains information about available options for electronic claims submission.

Each claim may contain charges for only one (1) beneficiary.

Procedure codes payable to douglas and breastfeeding and lactation consultants do not require modifiers unless specified in the policy.

230.200 National Place of Service (POS) Codes

9-1-26

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Telehealth Provided Other than in Patient's Home	02
Homeless Shelter	04
Telehealth Provided in Patient's Home	10
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Outpatient Hospital	22
Outreach Site	27
Provider's Office	11
Patient's Home	12
Public Health Clinic	71
Other Locations	99

230.300 Billing Instructions

9-1-26

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

230.300 Completion of CMS-1500 Claim Form

9-1-26

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	

Field Name and Number	Instructions for Completion
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
10d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.

Field Name and Number	Instructions for Completion
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for certified nurse-midwife services except for EPSDT services other than newborn care. Enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.

Field Name and Number		Instructions for Completion
20.	OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22.	RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23.	PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A.	DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. - On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. - Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B.	PLACE OF SERVICE	Two-digit national standard place of service code. See Section 272.200 for codes.
C.	EMG	Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	One CPT or HCPCS procedure code for each detail. For unlisted procedure codes, enter the description of the service and attach a procedure report.
	MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number		Instructions for Completion
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a.	(blank)	Not required.
b.	(blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a.	(blank)	Enter NPI of the billing provider or
b.	(blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

230.400 Clinic or Group Billing**9-1-26**

Multiple providers who wish to have payment made to a group practice or clinic may bill Medicaid on the same claim. If applicable, enter the Arkansas Medicaid Clinic Number in Field 33 after "GRP#." Enter the attending provider number in Field 24K.