

SAMPLE Nursing Facility Form (MA-3)

STATE OF MONTANA - PUBLIC HEALTH & HUMAN SERVICES

FOR USE BY NURSING HOMES

PLEASE TYPE OR PRINT

FORM NO. MA-3

(1) Assisted Living Services 112 Eastview Road Anytown, MT 59999	PROV. INFORMATION. (2) 000999999	MAIL TO: MONTANA MEDICAID DEPT. MA-3 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958	(5)
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PATIENT: LAST NAME FIRST MIDDLE INITIAL (3) Moreover, Dottie K.	M <input type="checkbox"/> S <input type="checkbox"/> F <input checked="" type="checkbox"/>	COUNTY 20	INDIVIDUAL NUMBER (6) 999999999	AUTH.		
DIAGNOSIS (7) Osteoarthritis	DIAG. CODE (8) 715.9	DATE OF BIRTH (9) 10 29 65	DATE ADMITTED (10) 12 20 11	STATEMENT PERIOD FROM (11) 02 01 12 TO (11) 02 29 12		
NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS (12) 029	LEVEL OF CARE (13) 2	TOTAL CHARGES (14) 3,595.79	(LESS) PERSONAL RESOURCES (15) 430.00	NET CHARGES (16) 3,165.79

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I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as are necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.

TOTAL CHARGES THIS SHEET	
TOTAL CHARGES THIS MONTH	

PROVIDER'S SIGNATURE Addie Administrator DATE 03/01/12
 (17) (18)

Nursing Facility, MA-3s

Nursing facilities and swing bed providers bill routine services to Medicaid on the MA-3 form. MA-3 forms are used when billing for new residents and coinsurance days. Below are instructions for completing an MA-3. Required fields are indicated by an asterisk (*).

Completing an MA-3 Form		
Entry	Field Name	Instructions
1	Nursing facility – name and address	List facility name and address
2*	Prov. Information	The provider’s NPI/API/taxonomy.
3*	Patient	Resident’s last name, first name, and middle initial. Do not use nicknames.
4	Sex	F for female or M for male.
5	County	Enter the two-digit county number where the facility is located.
6*	Individual Number	Resident’s nine-digit Medicaid ID number
7	Diagnosis	Description of diagnosis
8*	Diagnosis Code	ICD diagnosis code
9*	Date of Birth	Resident’s birthdate in MMDDYY format
10*	Date Admitted	Day of admission to the nursing facility
11*	Statement Period	Enter the “from” and “to” dates being billed in MMDDYY format. Do not enter the day of discharge as “to” date.
12*	No. of Days	Number of billable days during the statement period. Billable days do not include unauthorized hospital hold days or unauthorized THV days, or the day of discharge.
13*	Level of Care	Enter 1 for skilled and 2 for intermediate. Medicaid pays the same daily rate regardless of the level of care; however, this field must be completed. Continued-stay reviews indicate whether the facility is a Level 1 or 2. If continued-stay reviews are not available, nursing staff are usually familiar with the level of care.
14*	Total Charges	Number of days multiplied by the Medicaid per diem rate. See the <i>How Payment Is Calculated</i> chapter in this manual for more information on the per diem rate.
15*	Personal Resources	This is the resident’s monthly obligation toward nursing facility care.
16*	Net Charges	Subtract the <i>Personal Resources</i> amount from <i>Total Charges</i> and enter the result here.
17*	Provider Signature	Authorized signature. This can be handwritten, stamped, or computer-generated.
18*	Date	Billing date in MMDDYYYY format. This date must be later than the “to” date of the statement period (Field 11).