



## Instructions for Completing the HCBS and DD Billing Form SFN 1730 – Claims Correction Void & Replacements

### Step- by -Step Instructions to fill out the SFN 1730 to void or replace a claim:

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|----------|---|
| <b>1</b> | <b>Provider Number</b> - Enter the seven-digit provider number you were given when you enrolled. <b>You cannot use your old five digit QSP number.</b> If you do, the void replacement will be rejected.  |
| <b>2</b> | <b>Provider</b> - Enter your name. <b>LAST NAME</b> first, then your first name, and middle initial, if used.   |
| <b>3</b> | <b>Billing Period</b> - Enter the billing period from the original claim you are voiding or replacing. <i>Use two digits for the month, two digits for the day and <b>four</b> digits for the year. Example: June 2015 would be entered as: <b>06/01/2015</b> through <b>06/30/2015</b>.</i>  |
| <b>4</b> | <b>Recipient’s (Client) Identification (ID) Number</b> - Enter the “Recipient (Client) Identification Number” that was on the original claim you are voiding or replacing.  |
| <b>5</b> | <b>Recipient’s (Client) Name (Last, First, Middle Initial)</b> - Enter the <b>LAST NAME</b> , first name and middle initial of the client that was on the original claim you are voiding or replacing.  |
| <b>6</b> | <p><b>Original Claim Number</b> – Enter the original claim number from the claim you are voiding or replacing. You can find this number on the Remittance Advice (RA).</p> <p>➤ <b>Note: If you are using an ICN from Legacy MMIS (the old billing system) you will need to add the century (20) between the 2nd and 3rd digit of the ICN.</b></p> <p><b>Example:</b> Original Claim Number (ICN) from Legacy MMIS – 1015015320010</p> <p>Claim number as it should appear on the SFN 1730 : <b>1020</b>15015320010</p> |
| <b>7</b> | <p><b>Void Replacement Boxes</b></p> <p>➤ Check <b>VOID</b> if you want to cancel the claim because no payment should have been received.</p> <p>➤ Check <b>Replacement</b> if you were paid incorrectly and you want to correct the mistake.</p> <p><b>Note: If you are replacing a claim you must fill out the billing sections of this form. Fill out the Procedure Code, From Day, Through Day, Units and Billed Amount the way you want to be paid. Your original claim will be replaced.</b></p>                  |
| <b>8</b> | <b>Sign and date</b> the billing form. <b>You must make a copy for your records.</b>  |

## **Questions?**

Contact the HCBS office before you send the void or replacement. Call 1-800-755-2604 and choose option #5

## **Things You Need to Know Before You Correct a Claim:**

These instructions are used by Qualified Service Providers (QSP) who want to void or replace a claim that was paid in error. **Void** means that no payment should have been received and you are requesting the transaction to be cancelled. **Replacement** means the claim was paid in error and you are now billing the way in which you want to be paid. You must fill out the billing section for the new claim to be processed.



### **Mail Completed Void Replacement Forms to:**

N.D. Department of Human Services  
Medical Services Division  
ATTN: HCBS Billing Form  
600 E Boulevard Ave Dept. 325  
Bismarck, ND 58505-0250

### **Remittance Advice (RA):**

You will receive a Remittance Advice (RA) each time a claim is processed. If payment is made, a check will be sent to you or deposited directly into your bank account. If you don't get paid, the RA will explain why the claim was reduced or denied. If you have questions about your RA contact the ND Health Enterprise MMIS call center at 877-328-7098.

### **Additional Forms**

Do not make your own photocopies of this form because they may be rejected by the scanner. If you need more blank forms they are available at your County Social Service office.